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Biological
& Medical
Serials

VOL. X. (NEW SERIES.) No. 5

MAY, 1901.

# THE OPHTHALMIC RECORD

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103 E. ADAMS STREET, CHICAGO, ILLS.

PUBLISHED ON THE FIFTEENTH OF THE MONTH.

SUBSCRIPTION RATES: IN THE UNITED STATES, CANADA AND MEXICO, $3.00 PER ANNUM, IN ADVANCE. OTHER COUNTRIES OF THE POSTAL UNION, 14 SHILLINGS.

THE OPHTHALMIC RECORD.
THE HIGH BUILDING, CHICAGO, U. S. A.

Entered at the Chicago Post-Office as second-class matter F. M. de Rivas & Co., Printers, Chicago

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The June number of the OPHTHALMIC RECORD will contain amongst others, an original article by Ella Rosalind Wylie, M. D., "Parinauds Conjunctivitis;" one by Frederick Herman Verhoeff, M. D., "The Theory of the Vicarious fovea Erroneous;" one by Carl Weiland, M. D., "The Controversy About the Dioptric Value of the Cornea;" one by William M. Sweet, "Rupture of the Iris from Contusion of the Eyeball." There will also appear Editorials, Abstracts, Reviews. Society Reports, Personals, and Items of Interest to the Profession.

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The RECORD particularly desires short practical papers on any subject connected with Ophthalmology. These will be published at as early a date as possible. It is understood that, unless otherwise arranged, original articles when accepted are contributed to the RECORD exclusively. Illustrative cuts will be made at the expense of the journal, and proofs forcorrection will be sent to authors when desired. Reprints with covers are furnished at cost. One hundred of these will be presented to authors *gratis* when a request for them is written on the original manuscript. The RECORD will be issued monthly, and each number will contain about 54 pages of reading matter.

Address all communications relating to Editorial Department to

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103 E. Adams Street, Chicago.

Subscriptions and advertisements should be sent to the publisher, The High Bldg., Chicago, Ill., U. S. A.

Sole Subscription Agents for Great Britain, J. RAPHAEL & Co., 51 Clerkenwell Road, London, E. C.

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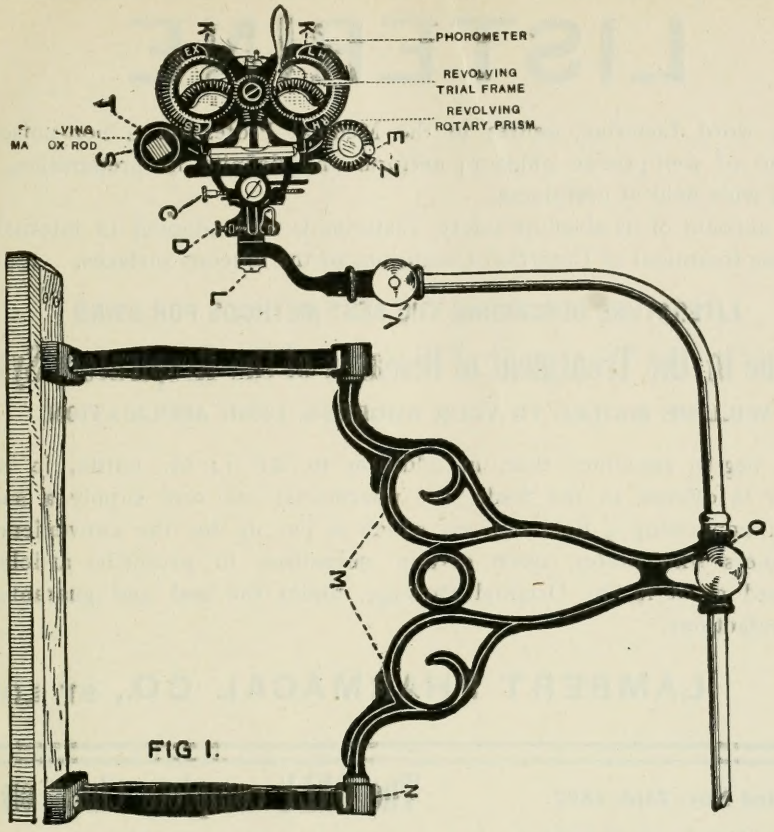


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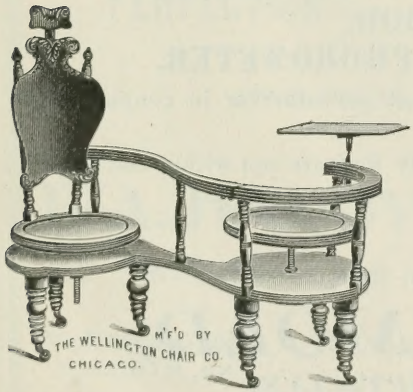


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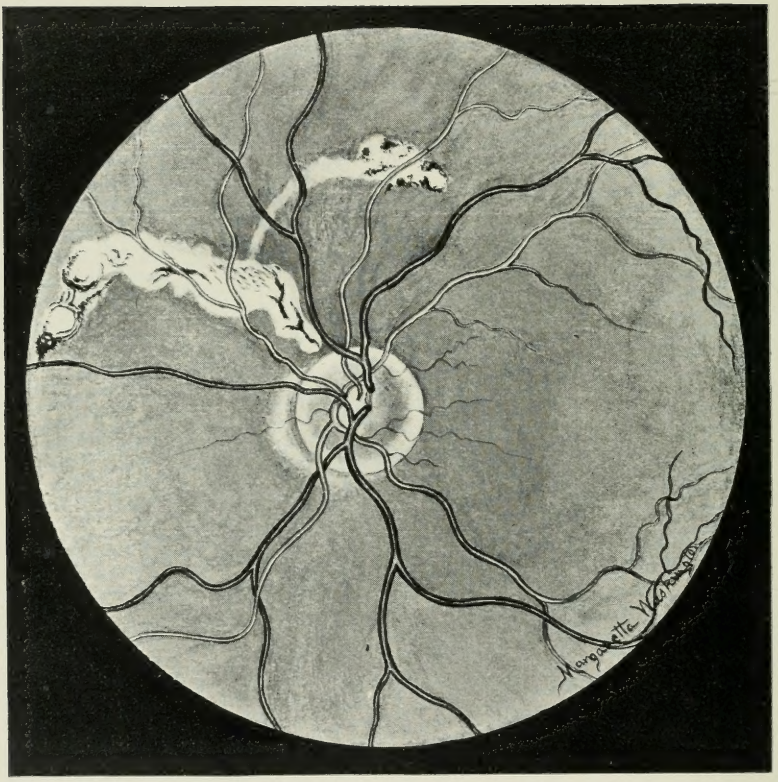

V-shaped Rupture of Choroid.

THE

# OPHTHALMIC RECORD

*A MONTHLY REVIEW OF THE PROGRESS OF OPHTHALMOLOGY.*

VOLUME X. CHICAGO, MAY, 1901. No. 5. NEW SERIES

## ORIGINAL ARTICLES.

### RUPTURE OF THE SPHINCTER OF THE IRIS AND V-SHAPED RUPTURE OF THE CHOROID ON THE NASAL SIDE FROM CONTUSION OF THE EYEBALL.*

By G. E. DE SCHWEINITZ, M. D.

PHILADELPHIA.

The frequency of choroidal rupture is variously stated by statisticians: Thus, E. Paun† gives the following figures: Hulse enumerates among 28,000 eye diseases in the Kiel clinic 22 cases of choroidal rupture; Knapp more than 12 choroidal ruptures among 18,000 patients; Hughes one rupture among 1,000 patients; while Pohlenz reports 46 ruptures among 5,000 patients. Combining these figures, we have 52,000 eye diseases and 81 choroidal ruptures, or about 0.155 per cent. Mooren gives the percentage as 0.014 (16 ruptures among 108,416 patients) and Cohn as 0.08 (8 ruptures among 100,000 eye diseases).

As is well known, choroidal ruptures usually occur on the temporal side of the disc, comparatively rarely on the nasal side, and very seldom in the horizontal direction. Hughes's statistics in this respect are interesting, viz.: temporal rupture, 82 per cent., nasal rupture 14 per cent., horizontal rupture 4 per cent.

Rupture of the sphincter producing mydriasis and minute notchings

* Read before the Ophthalmic Section of the College of Physicians of Philadelphia, March 26; 1901.

† Die Verletzungen des Auges, Wiesbaden, 1899, p. 131.

of the pupil border is more common than choroidal rupture. It is the lesion which probably always accompanies permanent dilatation of the pupil after a blow,—the so-called traumatic mydriasis Mooren reports 87 examples among 108,416 eye patients, and Cohn 29 cases among 100,000 eye diseases.

I have no statistics to show the frequency of the association of iris-sphincter rupture and choroidal rupture; nor do I know of any which have been collected. I think this double lesion must be comparatively uncommon. Personally, I have not observed it before the patient whose history follows presented herself for treatment.

Mrs. L., aged 31, married, reported for treatment on November 13, 1897, and gave this account of her ocular disabilities: Three weeks prior to her visit to my office, while standing behind of a golf player, she was struck in the left eye with the metal end of a golf club on the upward swing.

The immediate results of the blow were those usually seen after contusion of the eyeball: pain, tenderness, congestion of the globe, dilatation of the pupil and moderate disturbance of vision. The patient was judiciously treated by the local physician, atropine solution being instilled until all irritative phenomena had subsided.

When I examined her, the pupil was dilated 6 mm., and contained several characteristic notches in its border, particularly down and out. The media were clear, and with her correcting glass, viz.—$.75^{s}+2^{c}$ axis 90, the vision was $\frac{6}{6}$. Ophthalmoscopically, the following lesions were evident: Upward and inward from the disc border there was a somewhat V-shaped rupture of the choroid and retina. The left branch began just at the disc's edge; it was broad and slightly decked with pigment and terminated in a blackish end almost at right angles to the main break. One disc's diameter from the beginning of this tear a second somewhat curved, but much narrower lesion, extended in a semicircle above the disc, and terminated in an irregular, club-shaped end fringed with pigment. The rest of the eyeground was entirely normal and the retinal circulation unaffected. As the eye was white and quiet and the vision normal, no treatment was required.

During February of the present year the patient returned on account of some asthenopia. The fundus exhibited the appearances seen in the diagram. Her pupil was still notched and dilated. The glasses which she had been wearing with comfort since 1893 were as follows:

O. D. —1$^{c}$ axis 45, $\frac{6}{6}$.

O. S. —75$^{c}$+2$^{c}$ axis 90, $\frac{6}{6}$.

After mydriasis the following combination was found to represent the total refractive error:

O. D. —1.50$^{c}$ axis 45, $\frac{6}{6}$.

O. S. —1.50$^{s}$+2.25$^{c}$ axis 95, $\frac{6}{6}$.

These, with +1.50 added for reading, were ordered and have given entire satisfaction.

Evidently the points of interest in this case are these:

a. The association of choroidal and iris sphincter-rupture.

b. The situation of the choroidal rupture upward and inward from the disc and its peculiar branched shape.

c. The preservation or restoration of entirely normal vision.

The change in the refraction of the eye can hardly be attributed to this accident.

---

Ophthalmological and Otological Society of Washington, D. C.—The thirty-sixth session of this society was held on March 12, at the office of Dr. Henry A. Polkinhorn, who presented the paper of the evening on "The Use of Suprarenal Capsule in Ophthalmic Practice."

---

A permanent solution of the suprarenal capsule is made as follows:

| | |
|---|---|
| Suprarenal capsule | gr. 20 |
| Phenic acid | gr. 2 |
| Eucaine hyrochlorate B | gr. 5 |
| Dist. water | dr. 2 |

Macerate ten minutes and then filter.

Another permanent solution for the suprarenal capsule is as follows:

| | |
|---|---|
| Suprarenal capsule | dr. 1 |
| Boracic acid | gr. 16 |
| Cinnamon water | dr. 4 |
| Camphor water | oz. 1 |
| Dist. water enough to make | oz 2 |

Macerate four hours and filter.

# PTERYGIUM OPERATION, METHOD BY SUBCONJUNCTIVAL ANTERO-INFERIOR FIXATION.

By JOHN O. McREYNOLDS, M. S., M. D.

Oculist and Aurist for the Texas & Pacific Ry., Gulf, Colorado & Santa Fe Ry., Texas Midland Ry., St. Paul's Sanitarium, Vice-President of American Laryngological, Rhinological and Otological Society, Member of American Medical Association, Member Ex-Chairman of Section on Ophthalmology of Texas State Medical Association, Etc.

DALLAS, TEX.

(ILLUSTRATED.)

All forms of simple abscission requiring a break in the conjunctiva along the axis of the palpebral fissure must be more or less unsatisfactory, because this will demand one or more sutures, bringing the divided parts in apposition, and the line of union is apt to be associated with some thickening of the tissues and seldom is altogether as smooth as the normal conjunctiva, and the irritation consequent upon these conditions will serve to invite the neighboring subconjunctival vessels and thus cause a return of the growth in some cases. In my own experience, among a people who are afflicted with pterygium as frequently as the inhabitants of any part of the world, I must say that my results have been far more satisfactory with the method of transplantation than with any method of simple abscision. But the exact way in which this transplantation is accomplished has much to do with the suc-

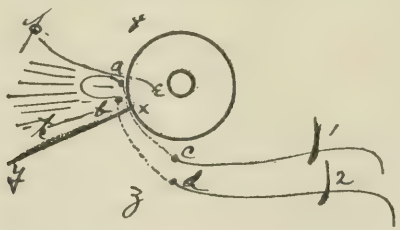


Fig. 1.

Showing needles 1 and 2 which enter the neck of the Pterygium pte. at *a* and *b* and then pass beneath the loosened lower segment of conjunctiva *x y z*, and then emerge at *c* and *d* below the cornea.

cess of the operation, and after a very thorough trial of the various procedures along this line I have finally adopted a plan which has never disappointed me a solitary time within the last few years. The details

of the operation are the following: 1. Grasp completely the neck of the pterygium with strong but narrow fixation forceps. 2. Pass a Graefe knife through the constriction and as close to the globe as possible, and then with the cutting edge turned toward the cornea shave off every particle of the growth smoothly from the cornea. 3. With the fixation forceps still hold the pterygium, and with slender, straight scissors divide the conjunctiva and subconjunctival tissue along the lower margin of the pterygium, commencing at its neck and extending toward the canthus, a distance of one-fourth to one-half of an inch. 4. Still hold the pterygium with the forceps and separate the body of the growth from the sclera with any small non-cutting instrument. 5. Now separate well from the sclera the conjunctiva lying below the oblique incision made with the scissors. 6. Take black silk thread armed at each end with small curved needles and carry both of these needles through the apex of the pterygium from without inwards and separated from each other by a sufficient amount of the growth to secure a firm hold. 7. Then carry these needles downward beneath the loosened conjunctiva lying below the oblique incision made by the scissors. The needles, after passing in parallel directions beneath the loosened lower segment of the conjunctiva until they reach the region

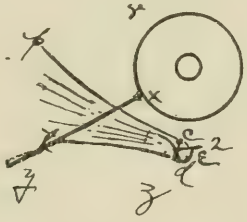

Fig. 2.

Showing Pterygium pte. fixed by a single stitch *c d* beneath the loosened lower segment of conjunctiva *x y z*, while the former site of the growth *p x r* is covered by the normal, smooth, stretched and thinned out conjunctiva *p x r*.

of the lower fornix, should then emerge from beneath the conjunctiva at a distance of about one-eighth to one-fourth of an inch from each other. 8. Now with the forceps lift up the loosened lower segment of conjunctiva and gently exert traction upon the free ends of the threads, which have emerged from below, and the pterygium will glide beneath

the loosened lower segment of the conjunctiva, and the threads may then be tightened and tied and the surplus portions of thread cut off, leaving enough to facilitate the removal of the threads after proper union has occurred. It is very important that no incision should be made along the upper border of the pterygium, because it would gape and leave a denuded space when downward traction is made upon the pterygium.

On the contrary, the elasticity of the conjunctiva is such that when this downward traction is exerted upon the head of the pterygium the conjunctiva becomes thinned out and smoothly applied to the sclera corresponding to the former site of the body of the growth and the margin of the conjunctiva coincides accurately with the sclero-corneal junction. Thus, when the operation is completed and the speculum removed, no stitch is seen, because it is hidden by the lower lid; the only denuded area is on the cornea. The former site of the body of the pterygium is covered by a thin and comparatively non-vascular conjunctiva, and what blood vessels remain are directed downward and not horizontally, and hence do not tend to encroach again upon the cornea. In fact, the whole vascular activity is concentrated beneath the lower lid, where it is not only removed from view, but protected from the irritating influences of dust and exposure, and the process of atrophy naturally and surely follows. In the meantime, the corneal wound heals quickly and the thin conjunctival tissue becomes closely adherent to the sclera in the palpebral opening. After a few days the single stitch can be removed and the old pterygium will be found firmly adherent to the sclera and hidden beneath the loosened lower segment of conjunctiva. If the head of the pterygium is very large it may be cut off before the growth is drawn down beneath the loosened lower segment of the conjunctiva. The general direction of the traction threads is vertical, but generally it is best to incline them in such a way that they will emerge from that part of the conjunctiva, which lies below the cornea. This may be necessary many times in order that all of the denuded sclera may be completely covered by smooth conjunctiva, and if the conjunctiva should slightly overlap the cornea at any point it can easily be trimmed smoothly away without interfering with the desired result.

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The New York Eye and Ear Hospital has opened its new pavilion for the treatment of communicable diseases. It is the gift of Mrs. Evyln Bliss and her daughters in memory of the late Jas. N. Platt.

# THE CLOSED ARTIFICIAL EYE.

By J. L. BORSCH, M. D.
PHILADELPHIA.
Ancien Chef de Clinique du Prof. de Wecker. Paris.

(ILLUSTRATED.)

The fitting of artificial eyes has occupied our attention for some time, and the number of cases in which we were obliged to be contented with a result that left much to bed esired, not only as regards a perfect mask of the deformity resulting from enucleation, but also the discomfort of the patient, decided us to seek for a remedy.

We accordingly commenced a series of experiments, first trying an eye to which was attached a gold spiral spring, connected with a gold plate, which in turn was intended to rest on the stump.

We soon abandoned this idea on account of the secretion excited by the spring, which was quite difficult to cleanse.

In 1894, after a number of experiments with different forms of artificial eyes, in cases where the ordinary ones failed to give satisfaction (deep socket, conjunctival inflammation caused by the sharp edges of the ordinary prothesis, etc.), we finally conceived the idea of trying a solid half eye, which we manufactured in a very crude manner, i. e., by filling the cavity of an ordinary artificial eye with wax in such a way as to avoid a sharp edge and give the eye greater bulk.

The result of this experiment was so satisfactory in the cases in which we tried it that we decided to have artificial eyes constructed on the same lines.

Having occasion, in July, 1894, to visit Wiesbaden, Mr. J. L. Borsch, of Philadelphia, had Mr. Müller, the celebrated maker of artificial eyes, construct some eyes like our model, which he did in our presence.

Mr. Müller, after several trials, succeeded in making some eyes, but they were heavy and almost solid, and, at our suggestion, he made us several others, hollow and closed, that met with our approval.

These eyes, in spite of their seeming heaviness, were light and readily floated on the surface of water.

Mr. Müller, at the same time, made other models for us, and the cuts below will convey better than words an idea of the phases through which these eyes passed before we obtained the desired result.

In August, 1894, we presented these closed eyes at the de Wecker clinic in Paris, where they were tried, and we can report results that induce us to recommend them to the profession.

Later on, in Philadelphia, they were also tried on several patients with most satisfactory results.

In 1897 Dr. Schwenk, of Philadelphia, pleased with the good results obtained with these eyes, presented them in the College of Physicians to the section of ophthalmology.*

In 1898 Professor Snellen of Utrecht, presented the closed artificial eyes at the Holland Ophthalmological Society at Rotterdam, stating that they had been made at his suggestion by Mr. Müller, of Wiesbaden; and later they were shown in the exhibit made before the International Ophthalmological Congress at Utrecht, in August, 1899.

Professor Snellen, evidently, was not aware of the existence of these eyes since 1894, or of Dr. Schwenk's article in 1897.

It is but simple justice that Mr. Borsch receive the credit of this improvement. While we do not doubt that Prof. Snellen may have had the same idea of making closed eyes, but it was four years after we had introduced them.

Having thus briefly related the history of the closed artificial eyes, we will cite a few illustrative cases:

Case 1.—M. G., aged 43 years, lost his right eye 10 years ago, and has since been wearing a prothesis, such as are generally worn.

Although he procured his eyes from the best makers, he had always been annoyed by an abundant conjunctival secretion and the formation of granular excrescences, compelling him to forego the use of his artificial eye until he was cured of the unfortunate condition, which, beside the suffering, caused him to lose much time while a cure was being effected.

This state of affairs had existed for some time, when the patient called in May, 1897, and assured us that he would submit to but one more operation.

We removed all excrescences and dressed the wound, which healed rapidly.

Now came the question of the artificial eye, which was indispensable to the patient, owing to the position he occupied. He, dreading the idea of again using the artificial eye he had been in the habit of wearing,

* College of Physicians, Section of Ophthalmology, Trans. of the Section, February, 1897.

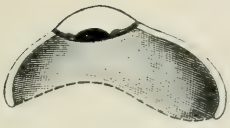


Fig. 1

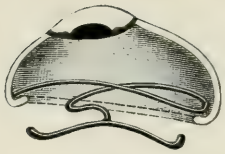


Fig. 2

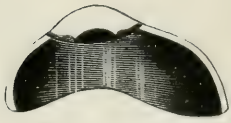


Fig. 3

Fig. 7

Fig. 4

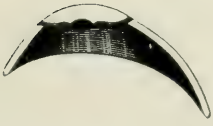


Fig. 5

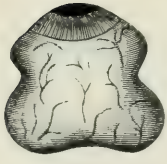
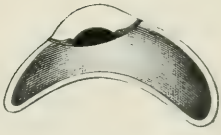


Fig. 6



besought us to indicate to him a way of avoiding a return of his former trouble.

We tried one of these eyes on this patient, and since he has worn this form he has never been annoyed by the reappearance of his former trouble.

He has now worn the eye ever since, whereas, with former models, the secretion appeared after wearing the eye a few days and the excrescences at the end of a month or two. The movements of the closed eyes are much greater than with any of the others he formerly used.

Case 2.—Another case was one in which, some 15 years ago, several oculists had proposed to perform an enucleation, which the patient refused and returned to his home in the South, where he continued a treatment which the oculists had advised.

He tells us that the contents of the eyeball were expelled through a large wound in the cornea, made by a piece of heavy wire perforating the eyeball, which was subsequently destroyed by suppuration.

This patient had already been using an artificial eye for some time past, which had caused him great inconvenience on account of the amount of secretion it excited; then again, the patient's orbital cavity being very deep, even a large eye masked the infirmity but imperfectly, and the movements of the eye were almost imperceptible.

Notwithstanding the care taken in their manufacture, these eyes always caused the patient annoyance in that they excited abundant secretion and provoked conjunctivitis, which necessitated him laying the eye aside at frequent intervals in order to allow the inflammation to subside. He complained particularly of the eye cutting him, which often necessitated removal, so great was the pain.

Being in Paris one day he called on us to be treated for a particularly severe attack of conjunctivitis, which was the result of irritation caused by the thin edges of his artificial eye.

We treated the conjunctiva with an astringent lotion, and discontinued the use of the eye for a time, until all the inflammation had subsided.

Now came the question of wearing an eye, and we concluded to try the closed eyes, which we did with the most gratifying result. He has not experienced the slightest inconvenience since he has been wearing this form of prothesis, which fills the cavity more perfectly; has better movement and does not cause the slightest irritation.

We are much gratified to learn that such authorities as Dr. Snellen

and Dr. Schwenk endorse the closed eyes, and recommend them to the profession, for since we have been prescribing them they have given entire satisfaction in every case.

For the benefit of our confreres who have not had occasion to become familiar with the closed artificial eyes, we have made a photograph of one floating on the surface of water whilst the ordinary eyes are seen at the bottom of the glass. (Fig. 7).

Fig. 1 shows a section of an ordinary eye; Fig. 6 that of the closed eye, which, as can be seen, is hollow, making it very light, and, practically speaking, has no edge, therefore cannot cut or irritate.

The intermediate figures show the different phases of development of the closed eye.

Note.—When an artificial eye irritates, even though we cannot feel any roughness when passing the finger over it, we can readily detect the slightest loss of smoothness by wetting a piece of absorbent cotton in a boracic acid solution (10 per cent) and passing it over the surface of the eye. If there be the slightest roughness we will feel a distinct resistance on passing the cotton gently over the surface; if the eye be perfectly smooth the cotton will encounter no resistance, but will glide smoothly over the surface without interruption.

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Dr. Thomas McDavitt, of St. Paul, read a paper on Glaucoma before the Minnesota Academy of Medicine, March 6th.

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*Lime Burns of the Eye*—W. C. Posey, in the *Ther. Gazette,* states that after removal of all the irritating substance the lids should be everted and every part of the conjunctiva carefully cleansed with oil or a diluted solution of vinegar, or water alone may be employed. Sugar is sometimes used in concentrated solutions, as cane sugar forms an insoluble compound with lime. Following the chemical neutralization the eye should be thoroughly cleansed with a boric-acid solution, 10 grains to the ounce, and ice compresses applied until all inflammatory reaction has subsided. As there is danger of involvement of the iris, if the cornea is affected, a solution of atropine should be dropped into the eye to dilate the pupil, and subsequently the use of olive oil or castor oil dropped into the eye will best promote the healing.

# SUCCESSFUL REMOVAL OF STEEL FROM THE VITREOUS.*

By CLARK W. HAWLEY, M. D.

CHICAGO.

(ILLUSTRATED.)

The case that it gives me pleasure to be able to present to you this evening is one that some of you will remember to have seen last spring. You will remember looking into the left eye and seeing a piece of steel lying in the vitreous imbedded in exudate, situated in the lower inner section. The surface of the steel was plainly visible and its shape readily made out. You remember all advised to attempt to remove same, but at the same time many doubted a successful removal beyond getting the steel, as so far as the records show such eyes are usually lost inside of six months.

I have purposely waited until ten months have gone by, so that I might not have the pleasure of reporting soon after operation a successful case and then having a troubled conscience later, as you know so many do suffer extremely and frequently in that way, though they make no public confession.

Just about a year ago now a bolt flew and struck the patient over the left eye, causing some slight injury about the same, but the physician who saw the case immediately after the accident said there was no injury to the ball. The man returned to his work the next day and continued for four or more months, and the eye must have behaved kindly indeed, as he had no or only very slight reaction from the entrance of the steel into the eye.

He came to me four months after the accident, complaining of a slight blurring of the eye, but the principal thing that annoyed was the dilated pupil. He wanted me to do something to bring it down.

On looking into the eye I very quickly made the diagnosis of steel in the vitreous. Turning to the exterior of the eye to find where it entered, I discovered running inward from the sclero-corneal margin a very faint dark line, situated a little below the horizontal meridian of the cornea. The piece must have passed through the sclera and between the lens and ciliary body without doing any injury to either,

*Read before the Chicago Ophthalmological Society.

and struck the posterior surface of the eye where you see the dark line, and not having sufficient momentum to go through the tissues at that point bounded to the point where you see the large exudate which later formed about it.

As the man's occupation is often violent, swinging a heavy hammer, a new condition is presented, in that at some time the steel and the anterior portion of the exudate were thrown from the main mass and turned completely over and falling down, thus exposing the steel to view, a very fortunate happening indeed, as it made our diagnosis easy.

I had an X-ray picture taken, and then accepted the very kind offer of the Chicago Eye and Ear College to make use of their large magnet, to see what action the same might have on the steel, especially as we could watch it. The magnet very promptly pulled the steel from its then bed, so that when I operated it occupied the position indicated by the cross, the painting having been made before the application of the magnet. I sent the patient to the hospital, and with the assistance of Dr. Horace M. Starkey I removed the steel in the following manner, taking a different course from the descriptions given of similar operations. Taking extra pains to make everything aseptic, I made a curved incision in the conjunctiva just to the inner side of the position over the ciliary body and between the internal and inferior recti muscles, raising this small flap and separating the tissue below, it contracted upward out of the field. I then plunged my cataract knife into the sclera as close to the ciliary body as possible and safe, and made a small incision downward and inward of just sufficient size to admit of a small Hershberg magnet. On plunging this into the vitreous and leaving it there a few seconds I withdrew it, but no steel followed. I repeated this five or six times; the last time I put it in and withdrew it quickly, hoping to catch the steel edgewise on the end of the magnet, which I was lucky enough to accomplish, as the steel followed the magnet out, coming on the end and edgewise. I now took two stitches in the conjunctiva and left the eye to the care of nature, and she proved a very good nurse indeed, for at the end of two weeks the eye was perfectly quiet and had healed with but the slightest reaction.

The pupil gradually returned to its normal size and the vision gradually improved from $\frac{6}{24}$ to better than $\frac{6}{12}$ at the present time with his error of refraction corrected, it is better than $\frac{6}{6}$.

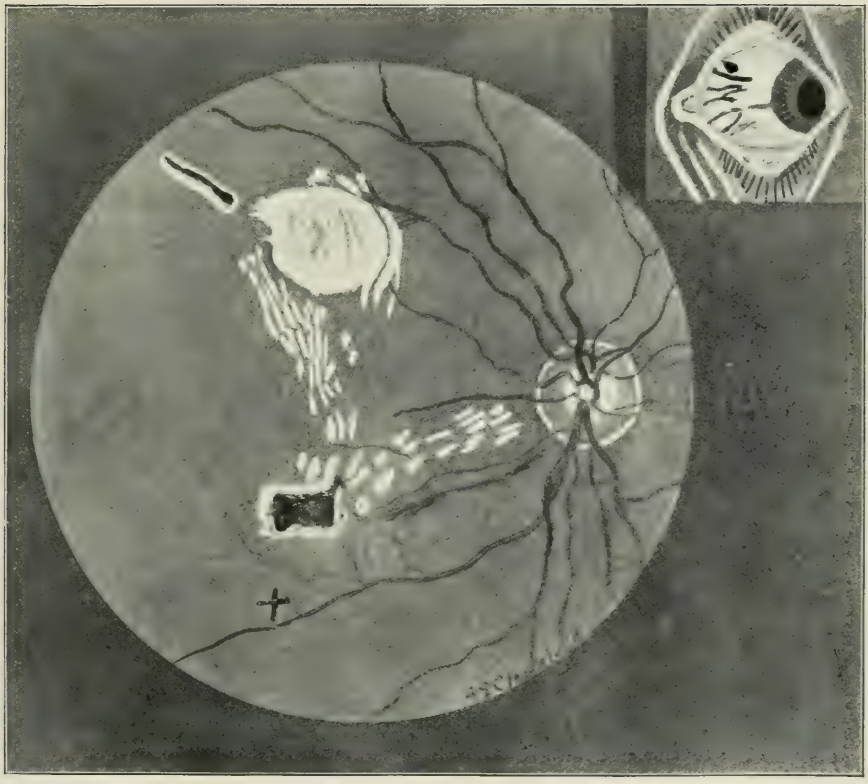

Fig. 1—Branched Rupture of Choroid, upward and inward from disc.

During the past ten months he has used the eye, and I have seen him occasionally, and for the first six or seven months the appearance of the interior of the eye did not change much from the appearance seen in the painting. I have not seen it since some four months ago until to-night, when, on looking into the eye, I find all the exudate has disappeared and only a few black pigment spots are visible and the eye looks very healthy.

I think that the young man may now feel that the eye is safely beyond the danger line, as very nearly a year has gone by and it has constantly improved instead of showing any signs of depreciating in value as an eye.

I am sure he fully appreciates the result which has proven so successful, and I am sure that we all feel that it is another illustration of what may be done to-day, when aseptic surgery of the eye is so easily and readily obtainable.

A few years ago, before asepsis and the magnet were understood, this favorable result would have been an impossibility even with everything so much in favor of a good result. Even now, so far as I know, I present the first successful case under similar circumstances, and I hope my result may encourage more frequent attempts to save eyes in which steel has entered.

I can now think of several cases in which I did enucleations which, were they to come under my care now, I should make a very great effort to save the eye, though in none of them were the chances of a useful eye good, still an eye-ball is better than a glass eye.

70 State street.

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Dr. A. R. Baker, of Cleveland, Ohio, will preside at the next meeting of the Association of American Medical Colleges, to be held at the Hotel Ryan, St. Paul, Minn., June 3rd.

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At a recent meeting of the Minnesota Academy of Medicine, held in Minneapolis, Dr. Thomas M. McDavitt, of St. Paul, read a paper on "Glaucoma," and Dr. Frank C. Todd, of Minneapolis, read a paper on "Sarcoma of the Choroid."

# ABSTRACTS

## FROM CURRENT OPHTHALMIC LITERTURE.

By G. E. de SCHWEINITZ, M. D. AND C. A. VEASEY, M. D.

**Concerning Peronine in Ocular Therapeutics.**—Smirnoff (*Wratsch, Nr.* 10, 1900, *abstract in the Archiv.d'Ophtalmologie,* December, 1900) attributes to this substance an important rôle in ocular therapeutics, because it has, on the one hand, the anesthetic action of benzol, and on the other the myotic action of morphine. Of the ocular anesthetics at our disposal cocaine, on account of its mydriatic action, is likely to do harm in glaucoma. Holocaine and eucaine notably have no action on the pupil. Peronine is always indicated in glaucoma. Smirnoff has tried peronine on 100 patients, thirty-five of them having absolutely normal eyes. The strength of the solution which is preferred by the author is 1/3 per cent, a solution of 1/100, or even of 1/200 strength, provoking a considerable hyperaemia and even an oedema of the conjunctiva. The anesthesia appears as promptly as that produced by cocaine, but is more durable. Nevertheless this action is subject to individual variations. For example, in 20 per cent of the cases the anesthesia produced by peronine manifested itself at the end of half a minute, but there have been cases where the anesthesia was not evident at the end of five minutes. Finally, fifteen cases (corneal pannus) proved refractory to the action of peronine. As far as the myotic action of the medicament in question is concerned, this is not very strong (1/2 mm.), but durable, persisting twenty-four hours after a second instillation and resisting the action of atropine. The action of the drug on the diffusion in the anterior chamber goes beyond that of eserine and is almost equal to that of cocaine. Being assured by previous experiences of the hypotonic action of peronine, the author tried it in glaucoma. Except in one case, where the instillation of a 1/3 per cent solution several times repeated did not produce anesthesia, the anesthesia was complete. In these cases neither hyperaemia nor lachrymation, nor oedema was more pronounced than in healthy eyes. Finally, in four cases of chronic glaucoma peronine was tried as an anti-glaucomatous remedy. The solution of 1/3 per cent was instilled in the proportion of one or two drops three to six times in

twenty-four hours. The results obtained have been in general favorable. The amelioration of the subjective phenomena was, above all, pronounced. The glaucomatous pains were lessened even on the first day. The objective symptoms have not proved intractable to this remedy. The intraocular tension was lowered, the anterior scleral veins became scarcely perceptible, in one case the cornea was cleared, and in three the vision was increased. Without being willing to assert himself definitely concerning the antiglaucomatous action of peronine, the author nevertheless believes that he is authorized to recommend this drug as an analgesic.

**A Note on the Ocular Analgesics, and Particularly Dionine.**—Darier (*Archiv. d'Ophtalmologie,* December, 1900) has for some time substituted for the applications of the powder of dionine a 5-per-cent solution instilled in the conjunctival cul-de-sac up to the production of chemosis, which is the sign that the anesthesia is commencing. Morphine and heroine produce an appreciable analgesia, but are liable to bring about intoxication. Codeine is not efficacious. Acoin has a caustic action which does not permit its employment, even in a 1-per-cent solution. Despeville praises the action of a 1-per-cent solution of acoin and its utility for suppressing the pain of subconjunctival injections and also of hypodermic injections.

**The Aqueous Extract of Cloves in the Treatment of Corneal Opacities.**—Krantchenko (*St. Petersburg Thesis, Abstract Archiv. d'Ophtalmologie,* December, 1900) comes to the following conclusions:

1. The aqueous extract produces a favorable effect in corneal opacities and augments the visual acuity. The influence of this substance is more pronounced the more recent the affection.

2. Inasmuch as this substance produces an irritation, even if it is a very slight one, it is necessary to abstain from applying it to cases of acute inflammation affecting the anterior segments of the eye.

3. The amelioration of vision is obtained as well in superficial as in deep opacities of the cornea. This amelioration is owing to a clearing and a disappearance of the corneal opacities, thanks to the absorption of the infiltrations which constitute the leucomas, not yet consolidated on the one hand, and to the return of the vitality of the atrophic foci in the proper tissue in the cornea on the other hand, this phenomenon being due to repeated hyperaemias provoked by the application of the medicament.

4. The aqueous extract of cloves also ameliorates vision in cases which have proved refractory to other agents used for the purpose of clearing the cornea.

5. In total cicatricial leucomas of the cornea it is necessary to persevere with the application of this therapeutic agent with the intention of preparing an area favorable for optical iridectomy.

6. In diffuse superficial opacities of the cornea it is preferable to practice the instillation of some drops of the extract twice a day, morning and evening, and repeat the instillation at each seance with an interval of five to ten minutes.

7. In circumscribed macules one can profitably combine the instillation of the medicament in the conjunctival sac with immediate touching of the affected part by means of a brush dipped in the same solution.

8. In very sensitive persons the instillation of the extract may be preceded by cocainization in order to prevent pain, even if this is of short duration.

9. A single prolonged application of the aqueous extract of cloves does not produce unpleasant results on the eye.

Krantchenko has applied the extract to sixty-two corneas and secured satisfactory results. The patients in question perceived amelioration at the end of seven to twelve days, and at the same time, or a little later, one could prove this by objective examination.

The extract is prepared in the following manner: Take 1,000 ordinary cloves and put them in a large vase and upon them pour distilled water. Then agitate the whole, and after allowing the contents of the jar to become quiet it can be seen that part of the cloves go to the bottom of the vase and the other part swim upon the surface of the water. Then take the cloves which have fallen to the bottom of the jar and dry them between leaves of blotting paper. After having stripped the cloves of their cortex, put them in a small coffee mill and reduce them to a coarse powder. This powder is preserved in a flagon of glass hermetically sealed. To obtain the extract put this powder in a small mortar of porcelain and pour upon it distilled water in the proportion of 1-15, and at the end of five minutes grind them from three to four minutes. After this pass the resulting mixture through a filter. The liquid obtained in this manner is slightly opalescent, has a burning taste and a reddish-yellow color. It is this liquid which the author uses for the purpose described.

**A Case of Zonular Cataract Due to Traumatism.**—Merz-Weigant (*Centralblatt für p. Augenheilkunde*, December, 1900) reports a unique case of zonular cataract produced by traumatism in a patient 31 years of age. The right eye had been struck by the knot of a wet leather whip, producing such great pain that the patient fainted. The eye was bandaged for ten days and the physician who treated it stated that blood was seen in its interior. Though the eye became normal in appearance vision was much reduced. A month and a half later, without any external cause, the vision again became much worse and continued to increase gradually for six months, since which time it has remained stationary.

Examination showed a delicate scar 2 mm. long situated as a tangent to the limbus. The anterior chamber was deep and there was a coloboma of the iris down and out, corresponding to the position occupied by the scar. The lens itself presented the typical appearance of a zonular cataract. As the patient was in the military service, and a sharpshooter of the first class, it is believed that the condition was not present at the time of the injury.

**Concerning the New Instructions for Bavarian Midwives for the Prevention of Ophthalmia Neonatorum.**—Neuburger, in discussing the value of different drugs in the treatment of ophthalmia neonatorum (*Abs. in Wochenschrift für Therapie und Hygiene des Auges*, December 20, 1900), states that in 1900 the following laws were passed:

1. Among the various effects which a midwife is obliged to carry to all cases of confinement there has been added a small blue bottle with a 2-per-cent solution of nitrate of silver.

2. Immediately after cutting the cord the margins of the lids and the surrounding parts are to be carefully cleansed with clean cotton and boiled clean water. In all cases in which the mother has suffered from a purulent vaginal discharge immediately after cleansing the eyes a drop of the silver solution is to be instilled into each.

The author states that this practice has been the custom in Prussia for some time, but is new in Bavaria.

**Concerning Sub-Conjunctival Injections of Acoin.**—Hirsch (*Archiv f. Augenheilkunde*, November, 1900) employs a 1-per-cent solution of acoin in the eye, and states that it produces anesthesia in both normal and inflammatory conditions in from two to five minutes; that it does not influence the pupil or accommodation and produces but slight

burning after instillation. For the removal of foreign bodies from the cornea, for galvano-cauterization, for Bowman's operation upon the canaliculus, and for cataract operations he considers acoin fully as good if not preferable to cocain. The greatest value, however, according to the author, is the power to produce anesthesia when injected beneath the conjunctiva, and it is always employed by him before making any sub-conjunctival injections of mercurial or saline solutions.

**A Case of Rapid Shrinking of the Eyeball After the Use of the Giant Magnet.**—Hirschberg and Ginsberg (*Centralblatt f. p. Augenheilkunde,* October, 1900) report an unusually rapid shrinking of an eye in which the Haab magnet had been employed for the removal of a splinter of steel from its interior. The patient received the injury to the right eye while hammering upon a steel plate. Vision was immediately destroyed. Two days later, after the sideroscope had shown the iron in the interior of the eye, an unsuccessful attempt was made to remove it with the small magnet. After remaining in the hospital for four weeks the patient was discharged and resumed his work for three weeks. During the latter part of this time, however, there was some pain in the injured eye, and it became irritated, soft and sensitive to pressure. There was a thin layer of blood on the posterior surface of the cornea, but no rusty spots. The iris, which had previously been blue, had become green and traversed by blood-vessels. The pupil was oval, but adherent to the corneal scar, and vision equaled the ability to distinguish moving hands at two feet. Light projection was good. The siderscope down and out gave the maximum reaction, which was confirmed by the Roentgen photograph. An attempt at removal with Schlösser's instrument having failed, Haab's magnet was employed. The application of the point of the magnet to the point of entrance and the employment of six amperes producing no result, twelve amperes were used and the magnet applied to the sclera corresponding to the location of the foreign body as shown by the sideroscope, when the splinter was drawn, anteriorly boring a hole through the iris and lying in the anterior chamber. It was then drawn out with a Hirschberg magnet through a small downward corneal section. Within two days there followed acute cyclitis, marked pain, injection and rapid shrinking of the bulb, so that in fifteen days it had become quadratic in shape. At this time enucleation was performed, the other eye being normal with 5/7 vision.

The examination showed that there was present a cicatricial mass of tissue connecting the scleral scar with an area where the choriod was found detached and which was richly traversed by blood-vessels and extended anteriorly through the vitreous. Within this mass the splinter was supposed to have lodged. It became surrounded by granulation tissue, in the growth of which there was associated the formation of pigment epithelium. It is assumed that the splinter was so firmly imbedded that upon the application of the large magnet it first tugged at the surrounding tissue and then tore through the choroid. The marked hemorrhage which resulted and which originated from the vessels of the newly-formed tissue, destroyed the vitreous. The latter then shrank, in turn being followed by detachment of the retina and later by shrinking of the whole globe.

The authors believe that if the smaller magnet had been entered through the old scar in the sclera the conditions described would have been avoided.

**Optic Neuritis from the Absorption of Thyroid Extract.**—(Thyroidine.)—Henri Coppez (*Archiv. d'Ophtalmologie,* December, 1900) states that the excessive use of thyroid extract may produce a decided optic neuritis, that is to say, a retrobulbar optic neuritis with central scotoma. The papilla, however, is a little more altered than it is in alcohol and tobacco neuritis. It is often hyperæmic, the veins overfilled, tortuous and clouded. The ophthalmoscopic symptoms are not in accordance with a considerable deterioration of the visual acuity, but they nevertheless exist. Coppez has had the opportunity of examining five cases of thyroid retrobulbar neuritis, four women and one man. The age of the patients varied from 30 to 40 years. All had absorbed for a long time thyroid extract, often in large doses, even triple the habitual maximum dose, the remedy having been taken for the purpose of reducing obesity. The amblyopia declared itself some months after the beginning of the medication. Dull sight once having appeared, the march of the ocular affection is rapid. In six weeks to two months the visual acuity falls to a tenth or less. Both eyes are generally affected, but one in a greater degree than the other. The prognosis is favorable. Some days after stopping the thyroid medication the affection is arrested, then remains stationary for a time, when the visual acuity returns to normal. Nevertheless the retinal vessels are affected. Some months must elapse before a satisfactory result

is obtained. The treatment consists in local blood-letting, nux vomica and the constant current.

**Two Cases of Amblyopia Following the Use of Jamaica Ginger.**—John Dunn (*Virginia Medical Semi-Monthly,* January 25, 1901) adds to the literature of this interesting type of amblyopia the history of two cases, one a male aged 19 and the other a male aged 39, who were seen one four and the other two months after the attack of blindness, which was attributed to drinking excessively of Jamaica ginger. Both patients had been addicted to alcoholic excesses. In both there was optic nerve atrophy, with changes in the diameter of the retinal vessels. Although there was marked depreciation of vision, it was by no means obliterated, being in one case O. D. 16/100, O. S. 16/30 and in the other case 8/200. Dunn agrees with Hiram Woods that the Jamaica ginger itself must have some influence in the production of this amblyopia and that it is not solely due to the alcohol which is contained in the ginger solution. Dunn does not hazard an explanation of the pathogenesis of the amblyopia, inasmuch as microscopical examinations are wanting.

(There seems very little doubt that this form of amblyopia, like that produced by methyl-alcohol, quinine and filix mas, is due, primarily at least, to an action of the drug on the ganglion cells of the retina, and that the optic nerve atrophy is secondary to their destruction. Indeed, there is no evidence of a special toxic action of ginger, and the indications are that the essence of ginger which has been consumed by those who have become blind is really an essence, the alcoholic constituent of which is methyl-alcohol, and that, therefore, the methyl-alcohol is the active agent.—G. E. de S.)

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At a meeting of the County Hospital, Omaha, Neb., Drs. H. Gifford, H. L. Burrell and H. B. Lemere were appointed Oculists.

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The California Eye and Ear Hospital, San Francisco, established four years ago, has outgrown its present quarters, and will erect a new $20,000 building. Dr. Tension Deane is President and Dr. Redmond W. Payne, Secretary.

THE
# OPHTHALMIC RECORD
*A MONTHLY REVIEW OF THE PROGRESS OF OPHTHALMOLOGY.*

VOLUME X. CHICAGO, MAY, 1901. No. 5. NEW SERIES

## EDITORIAL.

### HOW THEY DO IT IN FRANCE.

To some extent the impression is current, that American devotion to the pursuit of the Almighty Dollar impairs the scientific character of American medicine and surgery; and leads the profession of this country to regard with indifference breaches of professional ethics that would be severely censured in other countries. A sense of inferiority in these respects will have a tendency to keep down the standards by which professional conduct is judged and moulded. In so far as the impression is incorrect it ought to be removed. It ought not to occasion boastfulness, but it may strengthen self-respect to refer to some instances which point in quite the opposite direction.

At the meeting of March 10, 1896, there was shown before the Denver and Arapahoe County Medical Society, a binocular lens for use as a simple microscope or magnifier. The lens consisted essentially of two parts, joining each other at such an angle that when in use they should be respectively perpendicular to the visual axes passing through them; and decentered so as to increase the power of the two eyes to deal with divergent pencils of rays. This lens was described in the *Ophthalmic Review* for May, 1896. Certain modifications of the plan were shown and discussed at the meeting of the American Ophthalmological Society for 1896; and an account thereof published in the Transactions of the Society for that year; and in the *Annals of Ophthalmology* for October, 1896. Again, in the Transactions of the Section on Ophthalmology of the American Medical Association for 1897, the matter was still farther enlarged upon.

The binocular magnifier, in its various forms, has been quite widely adopted in this country. The descriptions of it have been copied in various European journals, among them the *Revue Generale d'Ophtalmologie,* 1897, page 576, where we find a very good abstract of the article that appeared in the *Ophthalmic Review.*

A little more than two years later, we find in the *Revue Generale d'Ophtalmologie,* for March, 1900, an article entitled, "Transformation de la Loupe Simple en Loupe Binoculaire et Stereoscopique, Par le Dr. Emile Berger." One who has watched closely the European literature of the past year may have noted that the binocular loupe of Dr. Emile Berger has been shown and its merits exploited, in learned societies in Paris and various other cities of France, in Brussels, Berlin, Madrid, before the Ophthalmological Society of the United Kingdom and elsewhere. Later, a monograph upon it was put out, proclaiming its value in the various arts and sciences, from general biology to dentistry and horticulture. This monograph makes considerable pretensions in the way of bibliography, including a reference to Dr. John Green's paper on obliquely placed lenses, in the Transactions of the American Ophthalmological Society for 1895. (Vol. VII, p. 329. My description of the lens is in that same volume, p. 742.) But nowhere does Dr. Emile Berger give any hint that the binocular loupe had been previously suggested. Each of the instruments is stamped, "Loupe Binoculaire Stereoscopique du Dr. Emile Berger." The instrument is patented (breveté) and the makers give warning regarding exclusive rights.

This "loupe binoculaire et steroscopique" differs in no essential respect from the binocular magnifier described four years earlier in this country. It is mounted in a hood, like one of the forms shown at the American Medical Association in 1897, but not so well suited as other forms to the use of the ophthalmologist. The lens is made in two pieces and is bi-convex, which makes it cheaper but inferior to the American instrument, which is made in one piece and is plane on the side toward the object. Then in the sample of the Berger lens the writer has seen, the two parts of the lens are not so well decentered; and its mechanical defects are rendered somewhat less glaring by the fact that it is made one-third weaker than the corresponding American instrument.

The case as above stated seems bad enough. Yet it is quite possible, that a Parisian might remain ignorant for several years of scien-

tific advances made in the wilds of North America. The pretentious bibliography might be one of those second-hand bibliographies, its compiler never having seen the volumes to which he refers. We cannot be sure, because Berger's article appeared in a journal that had previously given a good account of the American "Loupe Binoculaire," that he had read this account. But there has been a more glaring breach of literary decency than this.

In the monograph above referred to, Berger describes and exploits an arrangement of sphero-prismatic lenses mounted in spectacle or pince-nez frames, so as to be worn on the end of the nose. These are described and their advantages urged. The subjects of stereoscopic vision and the effects of decentering lenses are discussed, as though nothing of the kind had ever before been employed or thought of. The pretentious bibliography contains no allusion to Scheffler's monograph on orthoscopic lenses, published thirty-two years before; nor to any other of the many papers that have been written since, on the practical application of such lenses, to the needs of the patient or the operator. That Berger could have been ignorant of this literature is inconceivable. In regard to this, at least, he is self-convicted of endeavoring to take to himself credit for work previously done by others. Having followed this course in one case, the strong presumption is raised that he was equally guilty in the other; and any possible plea of independent discovery or "unconscious cerebration" falls to the ground.

An isolated instance of the sacrifice of candor and decency to the hope of gain should not be taken as evidence of a prevailing low ethical standard among European physicians, even though this pretense has been allowed by them to go for a year unrebuked. Still, when we remember the antitoxin patents of Behring and the newspaper exploitation of the theories of Schenck, we may at least be allowed such comfort as there is in the reflection, that the corrupting tendency of the pursuit of wealth is not peculiarly associated with our new country or our democratic institutions.

EDWARD JACKSON.

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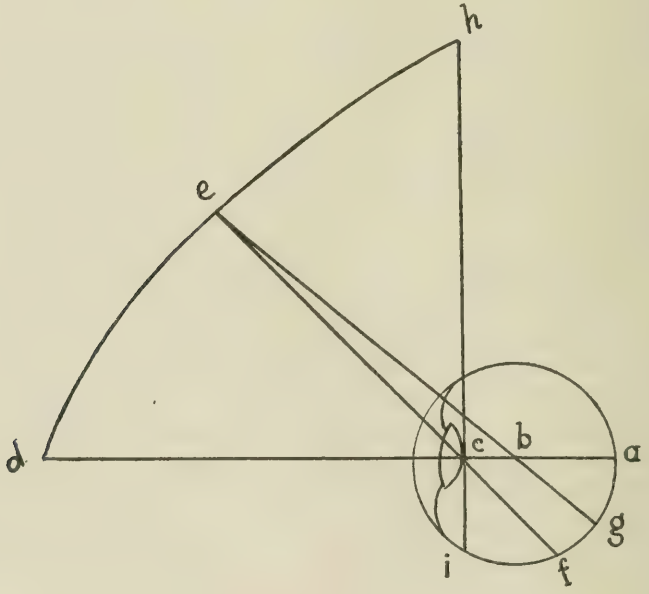
An entertainment was given at the Waldorf-Astoria, New York City, on the afternoon of April 12th, in aid of the Home of the Blind. Coquelin and Plancon entertained.

# CORRESPONDENCE.

## THE LAW OF DIRECTION.

Editors of the OPHTHALMIC RECORD.

Dear Sirs:—Dr. Suter's reproduction in the February issue of the RECORD of Dr. Savage's cut of November, 1900, and his criticisms of the article accompanying the same seem to give an opportunity for the re-opening of the subject of the law of projection, and I beg to submit the following figure, which is a slight modification only of the Savage cut. I have preserved the lettering of the latter, and added only the line *h i*, which is perpendicular to the line *a d*. This enables me to make plainer what I understand Dr. Savage's reasoning to be:




The angles *d c h* and *i c a* are right angles, and, therefore, equal; but the arcs *d e h* and *i g a* are not equal, because the point *c* is not the

center of both circles. Now, when the object *h* is moved in its arc to *e* and on to *d*, which is the same as turning the eye from *d* and fixing *h*, the image of *h* would necessarily travel from *i* to *a*. If you will construct a figure geometrically correct, you will find the arc *h e d* is one-fourth of a circle, while the arc *a g i* is at least one-third of a circle, which is very easily understood when it is remembered that the nodal point *c* is not the center of both circles. The conclusion is that while the object describes one-fourth of a circle its image passes through one-third of one, which is hardly reasonable. According to Savage's law, however, the center of retinal curvature and the center of rotation being the same, and the line of direction passing through this point, the image will pass through the same arc of a circle as the object. Furthermore, when the object *h* reaches the point *d*, it and its image at *a* are in two concentric circles, and, therefore, will be moving at the same rate as measured by arcs of circles; consequently the image *i* must have moved over the retina when it began to move toward *a* faster than it did as it neared that point, and this is another improbable phenomenon. In other words, the image *i* in its passage over the retina must have slowed down before it arrived at *a* to avoid arriving ahead of time. That the image moves more rapidly over certain parts of the retina than others may be seen also by considering the inclination of the ray of light *h i* to the surface of the retina at the different points of the same as the image passes from *i* to *a*.

To bring out clearly my reply to Dr. Suter's criticisms, I must first quote from him: "The line *e b g cannot* mark the direction of *e* when *d* is the point of fixation, because it is impossible for any light from *e* to reach the retina at *g*. We know that all the rays of pencils from *e* will be focused at *f* and that the line *e c f* is a straight line." If I understand the teachings of Dr. Savage, that the "pencils from *e*" are focused at *f* is the very thing he denies, and that they are *refracted,* bent out of their course, because of the obliquity with which they strike the cornea and lens, as well as focused, so as to reach the point *g* is just what he does claim. If rays of light are not so changed in their directions, will Dr. Suter please explain how rays of light from objects beyond about 50° to one side can miss the edge of the iris, pass through the nodal point, and reach the retina at any place? For instance, how can rays from *h* be focused at the point *i* on the retina?

Jas. W. Dunn, B. S., M. D.

Cairo, Ills.

## OPTHALMIC SECTION AMERICAN MEDICAL ASSOCIATION.

Baltimore, March 14, 1901.

To the Editor of the OPHTHALMIC RECORD.

Will you kindly give space to the following letter sent to oculists throughout the country? Numerous responses have been received. We trust that through your medium many will be reached whose addresses we could not obtain. Very truly,

HARRY FRIEDENWALD.

My Dear Doctor: The undersigned committee are preparing an historical exhibit of ophthalmoscopes and works on ophthalmoscopy for the coming meeting of the American Medical Association in St. Paul. The purpose is to commemorate the fiftieth anniversary of the invention of the instrument.

Will you kindly inform the committee as early as convenient what older models you will be able to lend them? Due credit will be given you. Very truly, HARRY FRIEDENWALD, Baltimore.

CASEY A. WOOD, Chicago.

Address communications to Dr. H. Friedenwald, 1029 Madison Ave., Baltimore.

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The fifteenth annual report of the Main Eye and Ear Infirmary has been presented. It shows the institution to be in the same healthy condition that has characterized it for many years.

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American Academy of Medicine.—The twenty-sixth annual meeting of the Academy will be held at the Hotel Aberdeen, St. Paul, Minn., June 1, 1901, and continuing through June 3. The principal features of the meeting will be a symposium on "Institutionalism" and another on "Reciprocity in Medical Licensure." Papers on both topics have been promised, as well as others on different subjects. The address of the President, Dr. S. D. Risley, Philadelphia, will be delivered on the evening of June 1, and the annual social session is to be held on the evening of June 3. Members of the profession are always welcomed to the open sessions of the Academy. The Secretary, Dr. Charles McIntire, Easton, Pa., will send the program, when issued, blank applications for fellowship, etc., on request.

# REPORTS OF SOCIETIES.

## SECTION ON OPHTHALMOLOGY—AMERICAN MEDICAL ASSOCIATION.

### PROGRAM.

OFFICERS OF SECTION.

Chairman—J. A. Lippincott, Pittsburg.
Secretary—E. C. Ellett, Memphis.
Executive Committee—H. V. Wurdemann, Milwaukee; Harold Gifford, Omaha; Casey A. Wood, Chicago.

TUESDAY, JUNE 4TH, 1901.

AFTERNOON SESSION.

1. Address of Chairman.
2. Treatment of Strabismus: Measures other than Operative.
Dr. Edward Jackson, Denver, Col.
3. Treatment of Strabismus: Operative Measures.
Dr. C. F. Clark, Columbus, Ohio.
4. Strabismus: Its Treatment. Dr. A. E. Davis, New York, N. Y.
5. The Cosmetic and Visual Results in Squint.
Dr. J. M. Ray, Louisville, Ky.

Discussion opened by Drs. C. M. Culver, Frank Allport, and C. F. Todd.

6. Concerning the Check Ligament.
Dr. J. E. Colburn, Chicago, Ill.

WEDNESDAY, JUNE 5TH, 1901.

MORNING SESSION.

Exhibition of Specimens and New Instruments.
Fiftieth Anniversary of the Invention of the Ophthalmoscope.
Exhibit of Ophthalmoscopes and Ophthalmoscopic Literature.
Address on the Origin and Development of the Instrument, Together with a Description of the Historic Exhibit of Ophthalmoscopes and Publications on Ophthalmoscopy Prepared for this Meeting.
Dr. H. Friedenwald, Baltimore, Md.
Address on the Life of Helmholtz. Dr. Casey Wood, Chicago, Ill.

7. The Comparative Values of Hyoscin, Atropin, Homatropin and Scopclamin as Cycloplegics. ffl

Dr. C. H. Baker, Bay City, Mich.

Discussion opened by Drs. Leartus Connor and C. M. Cobb.

8. Tarsadenitis Meibomica. Dr. M. F. Weyman, St. Joseph, Mo.

9. Report of a Case of Retroflexion of the Iris.

Dr. A. A. Hubbell, Buffalo, N. Y.

Discussion opened by Dr. Eugene Smith of Detroit.

WEDNESDAY, JUNE 5TH, 1901.

AFTERNOON SESSION.

10. Treatment of Heterophoria: Non-Surgical Measures.

Dr. George M. Gould, Philadelphia.

11. Treatment of Heterophoria: Surgical Treatment.

Dr. G .C. Savage, Nashville, Tenn.

Discussion opened by Dr. S. D. Risley.

12. Table of Paralyses of Ocular Muscles.

Dr. H. M. Starkey, Chicago, Ill.

Discussion opened by Drs. F. C. Hotz and Wm. Wilder.

13. The Extraction of Hard Cataract without Iridectomy.

Dr. S. D. Risley, Philadelphia, Pa.

Discussion opened by Drs. H. V. Wurdemann and F. C. Hotz.

14. Relation of Asthenopia to Disturbances of the Digestive System.

Dr. John McReynolds, Dallas, Tex.

Discussion opened by Drs. C. A. Wood and J. E. Weeks.

15. Ocular Lesions Associated with Constitutional Diatheses.

Dr. H. I. Jones, San Francisco, Cal.

Discussion opened by Dr. W. F. Southard.

THURSDAY, JUNE 6TH, 1901.

MORNING SESSION.

Exhibition of Specimens and New Instruments.

16. Economic Limitations of the Visual Acuity in the Various Trades and Professions. Dr. H. V. Wurdemann, Milwaukee, Wis.

17. Further Report on the Visual and Aural Qualifications of Transportation Employees. Dr. Frank Allport, Chicago, Ill.

18. Mules' Operation. With Cases.

Dr. Frank C. Todd, Minneapolis, Minn.

Discussion opened by Drs. L. Webster Fox and Frank Allport.

19. Plastic Operations for the Preservation of Sightless Stumps.

Dr. Harold Gifford, Omaha, Neb.

20. Report of Two Cases of Orbital Surgery.
Dr. Adeline Portman, Washington.
21. Enucleation in Two Minutes with Demonstration.
Dr. A. T. Mitchell, Vicksburg, Miss.

THURSDAY, JUNE 6TH, 1901.

AFTERNOON SESSION.

22. The Newer Pathology of the Retina, with Special Reference to the Changes Produced in the Ganglion Cells by certain Toxic Agents. Dr. H. Friedenwald, Baltimore, Md.
23. Atrophy of the Retina. Dr. D. S. Reynolds, Louisville, Ky.
24. A Case of Blindness due to Drinking Bay Rum compared with Reported Cases due to Methyl Alcohol and Jamaica Ginger.
Dr. H. Moulton, Fort Smith, Ark.

Discussion opened by Dr. H. Gifford.

25. Complete Recovery from Double Neuro-retinitis, Clinically Resembling Albuminria Retinitis, in a case of Prolonged Hematuria with Symptoms of Bright's Disease.
Dr. C. A. Veasey, Philadelphia, Pa.
26. Some Points to be Observed in the Use of the Perimeter.
Dr. Geo. F. Keiper, La Fayette, Ind
27. A Study of the Color-Changes in Chromogenic Bacteria.
Dr. C. A. Oliver, Philadelphia, Pa.
28. The Value of Excision of the Superior Cervical Ganglion of the Sympathetic in Certain Eye Diseases.
Dr. Geo. F. Suker, Toledo, O.

Discussion opened by Dr. Casey Wood.

FRIDAY, JUNE 7TH, 1901.

MORNING SESSION.

Exhibition of Specimens and New Instruments.

29. Herpes Zoster Ophthalmicus with Brief Report of Five Cases.
Dr. W. C. Bane, Denver, Col.

Discussion opened by Drs. Edward Jackson and H. M. Starkey.

30. The Corneal Lesions of Acquired Syphilis.
Dr. Wm. H. Wilder, Chicago, Ill.

Discussion opened by Drs. S. D. Risley and C. A. Wood.

31. Lachrymal Stenosis in Infants and Its Treatment.
Dr. Dunbar Roy, Atlanta, Ga.

Discussion opened by Dr. G. C. Savage.

32. Metamorphopsia Varians with a Report of Three Cases.
Dr. Wm. H. Dudley, Easton, Pa.

Discussion opened by Drs. J. E. Weeks and S. D. Risley.

33. Injuries of the Choroid. Dr. E. O. Sisson, Keokuk, Iowa.

Discussion opened by Drs. H. V. Wurdemann and Cassius D. Westcott.

34. New Instrument for Determining Position of Axes of the Eyes.
Dr. C. H. Williams, Boston, Mass.

35. Spontaneous Clearing of a Cataractus Lens.
Dr. Hiram Woods, Baltimore, Md.

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## THE ST. PAUL MEETING AND YELLOWSTONE PARK.

The following notice has been received from Dr. John Fulton, of St. Paul:

St. Paul, Minn., April 15, 1901.

To the Editor:

Kindly notice this extract from the *Journal of the American Medical Association* in your next issue, and oblige. Yours truly,

JOHN F. FULTON, M. D.,
Chairman of the Committee of Arrangements, **A. M. A.,**
BURNSIDE FOSTER, M. D.,
Chairman Committee on Entertainment.

Arrangements have been completed for an excursion of the members of the American Medical Association to Yellowstone Park. The Committee of Arrangements have finally succeeded in persuading the officials to open up the park a week earlier than usual in order to accommodate the Association. A special train will be run from St. Paul to the Yellowstone Park, and the railroad officials have promised to do everything in their power to make it satisfactory to all concerned. The rates will be very low, but how low cannot at this time be definitely stated. Those who attended the meeting in 1882 will remember with much pleasure a similar excursion that was run at that time, and these will not need to be informed that the one now promised will be full of enjoyment. Further announcements will be made later. The Yellowstone National Park contains more natural wonders than are to be found anywhere else in the world, and this will be a rare opportunity for our Eastern friends to see what this portion of our Great West possesses.

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To Commemorate Invention of Ophthalmoscope.—At the last

meeting of the ophthalmic section of the American Medical Association the undersigned were appointed a committee to arrange exercises, etc., at the coming meeting in St. Paul, to commemorate the fiftieth anniversary of the invention of the ophthalmoscope. The committee is preparing an historical exhibit of ophthalmoscopes and is endeavoring to secure such older models as they can borrow. Due credit will be given. Harry Friedenwald, M. D., 1029 Madison Ave., Baltimore; Casey A. Wood, M. D., Chicago.

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## CHICAGO OPHTHALMOLOGICAL AND OTOLOGICAL SOCIETY.

A regular meeting was held March 12, 1901, with the President, Dr. Casey A. Wood, in the Chair.

Dr. Clark W. Hawley showed a case *of a piece of steel in the vitreous,* reported in full on page ——.

*Discussion.*—Dr. Hotz said that Dr. Hawley deserved credit for having waited a year before removing his case of steel in the vitreous, because all such cases of removing steel from the vitreous or the interior of the eye were of no value if a reasonable length of time was not allowed to elapse after the operation, so that the result could be considered a permanent one. In this case the conditions for success were very favorable, inasmuch as there was no inflammation at the time, nor had there been any inflammation of the eyeball preceding the operation. He thought the Doctor must have been mistaken when he received the impression that all the members present at the meeting at which he exhibited the case a year ago had given an unfavorable prognosis.

Dr. Hawley had stated that he had made six attempts before he succeeded, and advanced the opinion that failure was due to the piece of steel becoming stripped off the magnet when he tried to remove it through the wound. Dr. Hotz was inclined to believe that the piece became attached to the magnet, but was held back by strong bands of adhesions, which pulled it away from the magnet again when the Doctor withdrew the point.

Dr. Hawley stated that Dr. Hotz had misunderstood him. The piece of steel originally was encysted, and by some blow which the patient received it shifted. After the use of the magnet, the piece of steel was perfectly free, hanging in the vitreous by itself, so that he

hardly thought that Dr. Hotz' explanation, in regard to its being held by bands of adhesions, was true.

*Hyaline.*—Dr. William H. Wilder presented a strong, healthy man, with *a growth on the cornea.* A similar case was reported and exhibited to the Society several months ago by Dr. Dodd. The man's left eye was perfectly normal. His right eye was normal up to two years ago, at which time a growth began to develop somewhat similar to pterygium (from the patient's description) from the upper outer side of the cornea. It extended onto the cornea and was removed by some physician. Later on it reappeared, and several months after it had been removed it began to spread and to cover the cornea completely. When Dr. Wilder first saw the patient on the 13th of last January at the Eye and Ear Infirmary, the whole right cornea was found to be covered with a translucent, irregular, homogeneous hyaline-looking mass, which was so dense as to prevent a view of the iris. He had only perception of shadows in the right eye. It did not in any way resemble pterygium; there was no fold of conjunctiva. He called attention to the remains of the growth and asked the members to imagine a similar growth extending over the whole surface of the cornea, only thicker. He suspected that the case was similar to the one Dr. Dodd and he had seen together, and also similar to the one Dr. Dodd reported a short time ago. Dr. Wilder curetted the cornea thoroughly under cocain anesthesia, with the result that most of the cornea has cleared up, and the central portion is quite free from the growth, so that vision has improved from almost nothing to 20/100. He thought another operation would succeed in removing all of this mass.

The tissue was hardened, embedded in the ordinary way, and stained with Pianesi's stain.

There is no question that the connective tissue that composes the large part of the growth has undergone hyaline degeneration, and possibly there is also colloid degeneration. There seems to be difficulty in differentiating the two. It was a surprise to him that he was able to remove the mass so easily and still preserve the surface of the cornea as it is seen to-day.

Dr. Oscar Dodd presented *a case of staining of the cornea following an injury by fragments of metal* in a man who had his eye injured two and a half years ago by a "splash" of iron as he was using a large machine punch. His eye was sore for four months, but he did not

know that anything penetrated the eyeball. His sight was damaged at the time of the accident to about the extent it is at present, and there has been no appreciable change since. About six weeks ago Dr. Coleman removed a piece of iron from under the conjunctiva in the lower cul-de-sac near the temporal side which he said was about a centimetre long and 2 or 3 millimetres in width. At the upper temporal part of the limbus is a small scar, the point at which a foreign body has probably entered the eye. The cornea is a reddish-brown color deposited in fine dots over most of it, but the center is clearer and has a different arrangement of the spots. It resembled iron rust very much, so that at first Dr. Dodd thought the stain was probably due to the metal. He has found, however, that just such a discoloration is produced by an infiltration of the cornea with blood. Hirschberg reports a case where, as the result of a blow, the whole cornea was stained a chocolate brown, which was associated with a hyphæmia when first seen. Fourteen days later it had changed to a greenish brown. Resorption was very slow, but the cornea had cleared at the end of two years. Pincus reports a case of injury where the anterior chamber was half full of blood when first seen, but three days later the entire cornea was colored a reddish brown. Later it had a greenish tinge and cleared up from the periphery, leaving in the center a greenish yellow ring.

Treacher Collins examined some of these cases pathologically and found the cornea infiltrated with a great number of highly refracting granules. These were scattered through the substance of the cornea with no relation to the spaces between the laminæ of fibrous tissue; they agreed in their spectroscopical appearance and chemical reaction with Hæmatoidin. He found in some of the cases also a substance which gave an iron reaction and was probably Hæmosiderin. He explains its occurrence as follows: Primarily it is a diffusion of Hæmoglobin into the cornea through Descemet's membrane, and Hæmatoidin which is insoluble in the corneal fluids is there precipitated.

Dr. Dodd also presented another case. The patient was a boy who sustained an injury four months ago, resulting in traumatic cataract. Patient was a blacksmith's assistant, and in paring the hoof of a horse something struck him in the eye, causing the formation of a cataract. Patient thought it was a piece of metal. Six weeks ago the bright, scarlet red appearance at the lower part of the pupil was first noticed, and the speaker has been unable to determine whether it is

due to blood or some foreign substance in the eye. If it is blood, it stays a bright, scarlet red very much longer than in most of such cases.

*Discussion.*—Dr. W. F. Coleman stated that some six weeks ago the patient appeared at his clinic with a stain on the cornea, presenting a history of a foreign body having struck the eye. Although the patient said the foreign body had been removed, he concluded that the statement was unreliable. Notwithstanding the patient had no pain or tenderness at the time, he concluded that there was a foreign body within the eye. In searching for an entrance point he drew down the lower lid and found a stain in the position seen to-night, but more marked. Pressing on the conjunctiva a sharp projection appeared, which confirmed the speaker's impression of a foreign body being within the eye. With a scalpel and forceps he cut through the conjunctiva and found a piece of metal projecting one mm. and lying obliquely on the sclera. He made several unsuccessful efforts to seize it, and was obliged to enlarge the scleral wound at the site of entrance. Then he was fortunate enough to seize the piece of iron and remove it. It was about fifteen millimeters long, and conical in shape. At its widest end it is three millimeters, and has an average width of two millimeters. Staining of the iris from a foreign body is not uncommon, but he thought this was the first case of staining of the cornea he had seen. It seemed to him so unmistakably an iron stain in appearance that he concluded that it was pathognomonic of a foreign body being within the eye.

Dr. C. D. Wescott was inclined to accept Dr. Dodd's view that it was a case of corneal staining from hematoidin. Dr. Dodd had raised the question of the possibility of corneal staining from metal. This focused at *f* is the very thing he denies, and that they are *refracted* was demonstrated in a patient presented by Dr. Wescott whose eyes had been penetrated by molten metal. In the left eye the staining of the cornea was undoubtedly metallic, as could be readily seen, and also the staining of the iris. Formerly the man had had a light blue eye. In daylight the iris was a reddish-brown now. Dr. Wescott had never seen a case like the one presented by Dr. Dodd, but as he looked at the coloration with the loup, it struck him as being a crystalline opacity, and undoubtedly hematoidin.

Dr. Dodd said, as regards it being a crystalline deposit, that hematoidin is insoluble in corneal fluid, and therefore the cornea is very slow in clearing up.

Dr. Hotz stated that the way to settle the matter of whether it was a metallic or blood stain in Dr. Dodd's case was by chemical examination. If Dr. Wescott could detect crystallized forms, he thought it would speak against a metallic stain. As he looked at the case he was inclined to think it was the result of a blood stain, which in the course of time changed its character to such an extent that it might be difficult to recognize it. In a case he exhibited to the Society over a year ago, when the staining was fresh, it showed a blue-colored, round disc, occupying the whole area of the cornea except a narrow streak around the periphery, which became smaller and changed in color, but finally it broke up into a number of small inlets, as it were. The opacity became cut through as if by canals in different directions, so that small plaques were left here and there. The case of Dr. Dodd resembled very much the one reported by the speaker, the original infiltration having become cut up in different directions. In his case clearing of the cornea has been going on, so that the last time he saw the patient there was only a small, hazy area in the center. Collins, in his paper, has stated that the clearing of the cornea is very slow in some of these cases. In some the infiltration is present for a great many years, and in one case reported the cornea had not been cleared up until after the lapse of nine years. He thought Dr. Dodd's case was the result of a blood stain.

Dr. Dodd thanked Dr. Hotz for his explanation of the condition, which he thought in a measure explained it. The blood was perhaps inside of the lens capsule, and for that reason it retained its brilliancy and was not absorbed.

Dr. Thomas A. Woodruff followed with the report of a *case of new growth (?) of the optic nerve.*

Dr. E. F. Snydacker presented some *pathological specimens.* He showed a number of sections of eyes upon which cataract extractions had been made, and made a few preliminary remarks about normal healing after cataract extractions.

Dr. Brown Pusey presented *pathological specimens.*

The fact of the very interesting discussion that has been taking place recently on the subject of glioma of the retina has suggested to me the idea that the members of this Society might be interested in seeing some specimens from such a tumor. The present discussion was first brought up by the papers of Flexner, published in the *Johns Hopkins Hospital Bulletin,* August, 1891, and Wintersteiner Ueber

Bau, Wachsthum and Genese des Glioma Retinæ, presented to the XI. International Congress in Rome, 1894. They first described the rosettes of glioma of the retina; and, principally from the study of these figures, they suggested the term neuroepithelioma retinæ to replace the term glioma retinæ. From the study of the arrangement of the cells in these rosettes, they independently concluded that these tumors arose from the external—the neuroepithelial—layer of the retina, and hence the term neuroepithelioma.

Two of the most recent papers in this discussion are by Emanuel on Glioma pars Ciliaris Retinæ, V. A. 1900, 161, 338, and Stanhaus, Zur Kenntness der Netzhaut Gliom, in the *Centralblatt für Allg. Path.*, 1900, XI, 258.

Dr. Pusey's specimen shows these rosettes very perfectly, and as they are the most interesting feature in the present discussion he brought sections showing particularly the rosettes.

From the study of these sections, he thinks there is no question that Wintersteiner's and Flexner's conclusions are wrong; he believes that his sections conclusively prove that in these tumors we have tumors of neuroglia tissue, hence glioma; that the rosettes of retinal tumors are similar formations to the rosettes of neuroglia tissue elsewhere in the nervous system.

The other specimen is simply something of a curiosity. In making histological sections, a small piece of iron was found in a dense exudate just posterior to the lens. The iron has been partly dissolved, and the parts immediately around it show the very beautiful Prussian blue reaction of iron.

Dr. Brown Pusey presented an *Ophthalmoscope* made to supply the demand for a small, light, compact instrument to carry in one's pocket.

The form of instrument primarily sought for was a concave mirror, with a hole in the silvering and the attachment of a +3.00 or +4.00 D. lens, which is all the ophthalmoscope necessary for ophthalmoscopy by the indirect method. It was found that for the covering of such a mirror, a back carrying a plane mirror would add very little in weight and cost, and would have the advantage of making it a complete instrument for retinoscopy. At the back of the concave mirror is placed a wheel, in which there are five lenses; a +2.00, a +4.00 for use in the indirect method, a +8.00 for use in examining on levels in front of the retina, a —3.00 for the unskilled user, who accommo-

dates when making direct examinations, and a —10.00 for examining myopes; there is also one plain hole in the wheel. The makers can vary the lenses; as, for instance, one oculist suggests that he would like a +2.00 in the space containing the —3.00.

We are confident that this combination will suggest itself as quite all that is necessary as an ophthalmoscope and retinoscope for the oculist and physician to carry in his pocket, and it will supply the demand of the student for a cheap, but complete, ophthalmoscope. It is not a refracting ophthalmoscope.

The instrument weighs a little less than two ounces. It is one-fourth of an inch thick, and two and one-half inches long. It is a substantial instrument, and has locking joints. The instrument is being made by Chambers, Inskeep & Co., and they promise to have it on the market very soon. The makers say that the selling price of the instrument will be $3.00, which, regardless of its completeness, makes it the cheapest instrument on the market.

*Discussion.*—Dr. E. F. Syndacker did not think that the section of Dr. Pusey showed the case to be one of glioma, for the reason that the tissue had none of the characteristics of that tumor. It was a common thing in congenital anomalies of the retina to find the so-called rosettes. In anomalous conditions of the retina, in cysts of the retina, rosettes were very apt to be found where there was no trace of glioma. The glioma might be nothing more nor less than anomalous growth in the distribution of the cells of the retina.

Dr. Pusey said it was a well known fact that these rosettes have been found in microphthalmic eyes. The diagnosis of glioma was not made from the one or two sections shown this evening. The final proof of the presence of tumor in this case was found in the invasion of neighboring structures by tumor cells.

Dr. Wescott reported a *case of sarcoma of the choroid.* The eye was removed in December, 1899.

There was no recurrence of the tumor in the orbit or surrounding parts, but the patient died in December, 1900, from metastatic growth in the liver. There were found, in addition to an extensive involvement of the liver, a tumor at the left of the vertebral column just outside the pleura, and several nodules in the lesser omentum. The tumor cells wherever found were more or less pigmented. Dr. Wescott exhibited a portion of the eye, which was mounted in jelly, and histological sections from the eye and from the various metastatic growths.

## WILLS' HOSPITAL OPHTHALMIC SOCIETY.

Meeting held in Philadelphia, March 25, 1901, Dr. P. N. K. Schwenk in the chair.

*Primary Sarcoma of the Iris.*—Dr. Conrad Berens presented a most interesting case illustrating the secondary stage of primary sarcoma of the iris. The patient, a young man, who was free from any symptoms and obtainable history of syphilis or tuberculosis, first noticed the affection some three years previously. Imbedded in a partially degenerate and comparatively uninflamed iris-tissue were five irregular tumor-masses, over and through which some fine vessel ramifications could be plainly seen. The plane of the iris was pushed forwards. The pupillary area, which was slightly distorted, contained some meshes of glistening lymph. The crystalline lens occupied its normal position. No view of the fundus could be obtained. Intraocular tension was increased to plus two. There was not any ciliary tenderness.

Based upon these findings and the fact that the therapeutic tests for syphilis and tuberculosis had been unsuccessfully applied, Dr. Berens felt certain of the diagnosis, and believed that it would be proven after enucleation.

Dr. Frank Fisher tended to the opinion that there might be an irido-cyclitic element in the case. Dr. William W. McClure agreed in the diagnosis, giving a number of differential points between the one almost certain and the other possible processes. Dr. Charles A. Oliver, while fully agreeing in the etiology of the condition, was disposed to place the main bulk of the growth in the ciliary body.

*Embolism of the Central Retinal Artery.*—Dr. Frank Fisher exhibited a series of water-color sketches of several stages of a case of embolism of the central retinal artery (full details of the case to be published in full later). The patient, a young subject with a mitral murmur, gave the usual history of sudden blindness. Besides the characteristic eyeground of the affection, all of the main retinal blood currents, both arterial and venous were found to be interruptedly flowing in their proper directions; the curious fact being that the venous currents were traveling with twice the rapidity of the arterial.

Dr. McClure stated that he had had the opportunity to see two cases in their very earliest stages. One of the early changes he had found, consists in a lead-tinted area bounded upon its superior and inferior borders by two fine vascular twigs that are not ordinarily

observable, giving the area of infiltration a caudate form. The second of his cases which but partially closed the arteries showed broken blood currents in the two principal veins running in the direction of that which is pursued by the ordinarily contained blood. Dr. Schwenk had seen six clinical cases of central retinal artery embolism; one of which occurring in Dr. Harlan's service at the Hospital and which showed the vascular beadings, he had made careful drawings of, these being published in the Transactions of the American Ophthalmological Society. His experience had been that vision seldom if ever returns in the pronounced types of the disorder. Dr. Charles A. Oliver was greatly interested in the double rapidity of the venous current seen in Dr. Fisher's case, and spoke of the difference between trophic and functional disturbance found in these cases, drawing attention to the two forms of vascular circulation in the human retina. He made mention of the possibilities of endarteritis, vessel-spasm and thrombus in such cases, and did not deem a differential clinical diagnosis as entirely certain in every instance as the several conditions might be coexistent. Dr. Walter L. Pyle called attention to several cases in ophthalmic literature, in which, although there was complete embolism of the central artery, a small sector in the field of vision was preserved; ophthalmoscopic examination showing a cilio-retinal artery supplying the corresponding retinal area. Dr. Fisher did not believe that there was any collateral retinal circulation. He considered the most remarkable feature in his case to be the visibility of both the arterial and the venous circulation in the retina at the same time. He deemed prognosis as to vision doubtful when an embolism is situated within the retina as it is not likely to undergo absorption in such a position.

*Successful Extraction of Manganese Steel from the Crystalline Lens.*—Dr. Schwenk showed a forty-five-year-old man from whom he had successfully removed a piece of manganese steel from the left lens. The points of interest in his case consisted in the facts that the form of steel which was imbedded in the lens substance was but feebly attracted by the magnet and that much of the lens matter which had appeared transparent at the time of the removal of the foreign body afterwards became opaque and greatly swollen.

Dr. McClure gave the details of a case of steel in the lens in which, before making the corneal section with a von Graefe knife, he created a path or track through the lens fibres with a Hay's needle for the

escape of the foreign body. After this was done, it was but necessary to bring a magnet tip to within two inches of the external wound, the foreign body fairly leaping out of the eye through its open pathway. The lens mass was then expressed without any trouble. Recovery was uneventful, a corrected vision of two-thirds of normal being later obtained. Dr. Oliver stated that not sufficient attention had been paid to the relative traction qualities of the different forms of steel, all being classed alike. He believed that extremely hard and brittle manganese or nickel steel are so dense and contain so much nonmagnetic material that the electric current cannot permeate the mass sufficiently to attract enough of the ferric elements to produce expulsion of the foreign body unless the magnetic force be very greatly in excess of that which is obtained by the ordinary forms of clinical magnet. He also called attention to the fact that on account of the very great brittleness of manganese steel, workmen should be taught to be extremely careful in the handling of such material as it is particularly liable to fracture. In all of his cases, where permissible, he endeavors to remove as much of the clear lens material as possible, this being readily accomplished by means of a grooved spud. Dr. Berens made it a rule to evacuate all of the clear lens matter that could be done with safety to the organ.

*Removal of Congenital Cataract.*—Dr. Oliver exhibited a nine-year-old Hungarian boy from whom he had successfully removed two congenitally opaque lenses by free discission, obtaining a corrected vision of normal in each eye. The case was of interest as showing the good effects of diametrically opposed forms of treatment in the two eyes, necessitated by an attack of secondary glaucoma from stoppage of lymph flow caused by a blocking of the pupillary area. He did not consider such a complication of any great moment in the young, otherwise healthy eye, as it rapidly subsided under appropriate treatment without any damage to the organ.

Dr. Schwenk presented a case of congenital cataract in a white male of thirty years of age, the interesting point being that three brothers were similarly affected, while three sisters had normal eyes. Ten days previous, a free discission of the right lens was done by the Senior Resident Surgeon of the Hospital. The lens rapidly swelled and several opaque pieces of lens matter fell into the anterior chamber. One week later, although intraocular tension was normal and

the eye was quiet, much of the remaining lens material was extruded by means of a grooved spud. At present the eye is practically well.

*The Immediate Results of Mules' Operation.*—Dr. Oliver showed the immediate results of a Mules' operation in a case of panophthalmitis. The patient was a twenty-three-year-old sailor, who had lost his eye about a year previously from gonorrheal infection. As a large area of the sclerotic coat at the upper outer corneal limbus was softened and infiltrated he took advantage of excising this part while converting the circular corneal area into a lozenge of sufficient size to admit the placing of the glass ball into the scleral cavity. In less than five days' time, without any reaction, the conjunctival sac was clean and the eyeball was freely mobile. In accordance with a suggestion from the Senior Resident Surgeon of the Hospital he had most successfully employed pressure bandages instead of the usual iced compresses. He expected, as is his rule, to discharge the case from the wards of the Hospital as cured in a few days' time. He will order a properly adapted artificial eye for the patient as soon as the socket becomes fixed in size. He had learned from experience that throughout the entire procedure it is always best to avoid touching the borders of tissue intended for coaptation by any fixing instrument, and always to remove the ocular contents with a number of moistened cotton swabs twisted upon the end of clean applicators. He has broadened the field of the usefulness of the procedure to cases in which he had previously had no expectation of good results, employing the plan with immediate cessation of all inflammatory signs in cases of panophthalmitis and even localized tenonitis in which even isolated areas of softening in the anterior portion of the sclera had become evident.

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## SAN FRANCISCO SOCIETY OF EYE, EAR, NOSE AND THROAT SURGEONS.

Regular meeting, February 21, 1901. F. B. Eaton, M. D., President, in the chair.

Dr. Robert D. Cohn presented a case of *Luxation of the Anterio-inferior End of the Quadrangular Nasal Cartilage* in a girl of nine.

Dr. L. C. Deane presented a boy 8 years of age who was *Shot in the Left Eye* from a distance of 70 feet on Feb. 10th. The gun was loaded with new No. 7 shot. The shot passed through the skin of the

left arm and the left side of the head. The lower lid was penetrated with two shots which apparently entered the globe through the sclera at places corresponding to the wounds in the lid, one at the lower, inner, and anterior quadrant and the other at the lower, outer, and anterior quadrant of the globe. Dr. Deane saw the boy for the first time to-day (eleven days after the accident), L. V., perception of light only: Tension,—T. (subnormal). The ocular conjunctiva is congested without signs of inflammation. Cornea and aqueous clear. Iris discolored (due to blood). Dilates readily to atropine, none having been used previous to consulting him. The iris shows no signs of inflammation. Lens and anterior capsule normal in appearance. With the ophthalmoscope there is no red reflex in any direction. The patient has practically suffered no pain since the accident except one day. No pain on pressure. The history of the case is not complete, as he was seen for the first time to-day and the examination was hurried.

Dr. Deane intended making a negative by Röntgen rays, which may elucidate certain facts. The questions of interest in such a case are: 1. What are the chances for recovery for this eye? 2. Should an attempt be made to remove the foreign body or bodies, as in this case? 3. Are the dangers of sympathetic ophthalmia decreased from an eye where no purulent infection or inflammation follows the traumatism eleven days after the accident? Of course these questions resolve themselves into the main issue: Should an eye of this character be removed?

The President presented a young man aged 19 with a *Chemical Precipitate in the Cornea from Methylene-blue and Protargol.* Patient was first seen three weeks ago, and then stated that six days before the left lower eyelid became inflamed and was subsequently poulticed with vinegar and milk. The day before he was seen a "deep" pain came on in the left eye, which prevented sleep at night.

Examination showed a superficial ulceration of the left lower lid touching its edge, and crusted with dried pus. There was muco-purulent conjunctivitis. On the cornea, at its center, was seen a stippled appearance; the iris was slightly discolored, and the ciliary region tender to the touch.

After cleansing the lid with pyrozone, and washing out the conjunctival sac, a 20% solution of protargol in water was instilled, and then a few very small crystals of methylene-blue placed upon the

beginning ulcer at the centre of the cornea. It was noticed after a few minutes, that the fluid in the eye was greenish, and a larger loss of corneal epithelium was now seen, being about 3 mm. by 4 mm. in area. Atropine was ordered.

The following morning the eye was much better, and the epithelium had been restored over the denuded corneal area, but underneath it was a buff-colored deposit which was between the epithelium and Bowman's membrane. During the past three weeks it has remained the same. It is opaque by oblique illumination, but is transparent, as the details of the iris can be seen through it.

The eye is free from all irritation and has a refraction corrected by: +1.00s ⊂—0.50c. axis 45, and V.= $\frac{20}{16}$, so that practically the vision is not damaged as the V. of the fellow eye when corrected by same lenses is $\frac{20}{16}$. But, for cosmetic reasons, a remedy is desired. The epithelium will, of course have to be scraped off to allow any dissolving solution access. The President would be glad to receive any suggestions.

Regular Meeting, March 21st, 1901. Dr. F. B. Eaton, President, in the Chair. Dr. W. A. Martin presented an old lady of sixty to seventy years of age with *Apparent Xerosis of the Conjunctiva.* He first saw her six weeks ago. She had been told by a physician that she had syphilis, and he had been treating her on that basis. She said she had eczema.

Dr. Martin found there was a lash that was rubbing in the eye and thought perhaps he had discovered the source of the trouble; but after it was removed the trouble kept on just the same. There seems to be a gradual obliteration of the conjunctival sac. There are patches on the conjunctiva, and there seems to constitute a sort of xerotic condition. When the eye is washed with an ordinary wash there are flakes which seem to come away like oil flakes in water. Dr. Martin could not say that the condition is syphlitic. He had never seen a similar condition, and thought he would bring the patient to see if any of the members had seen anything like it. They would notice that the conjunctival sac in the left eye is very narrow, but it is not obliterated to a mere margin as in the right eye.

Discussion. The President asked Dr. Martin whether there is any condition of malnutrition.

Dr. Martin: Only that she said she had eczema, if that is a condition of malnutrition. It is so claimed by some.

The President asked whether there is any hemeralopia?

Dr. Martin: That is entirely a juvenile condition and is not present in a case where the patient is of this age.

Dr. R. D. Cohn thought the case very interesting. He considered, however, the red patches to be of secondary importance. The chief thing of importance is the gradual obliteration of the conjunctival sac. This he had never seen and in a case of this sort it was impossible for him to venture even a guess. He should imagine that it is not syphilitic and would not use anti-specific treatment.

Dr. Merritt said he would like to mention a few points about the case, having seen it about six months before. Eight months ago it was progressing slowly. There was a little more œdema about it but the conjunctival sac was not as small as it is now, and he did not consider it syphilis and did not give her any specific treatment. She told him that a physician was treating her for syphilis. In this case the foundation of the palpebral conjunctiva rests upon a deep bed of homoplastic tissue. It presented to Dr. Merritt's mind the same conditions we find in mouth in lupus, while where there are patches on the mucous membrane of the mouth.

Dr. Fredrick presented a case of *Synchysis Scintillans* of senile origin, and stated that it is only remarkable for the fact that it is found present in the outer and lower half of left eye, and not in both eyes as is the rule. He found these light golden spots confined in the outer and lower half of the left eye. This is strictly a senile change, as the man is about 70 years of age. The only remarkable thing about this case is the location of the synchysis.

Dr. McKee then read an essay on *Suppurative Middle Ear Diseases. Their Complications and Operations.*

The President wished to call attention to the case presented by him at the last meeting, viz: the young man with a precipitate or deposit between the corneal epithelium and Bowman's membrane formed by the joining of methylene-blue and protargol. Experiments he had made by mixing these substances on a piece of porcelain had yielded a similar buff-colored deposit which he had found soluble in a solution of potassium cyanide.

## OPHTHALMOLOGICAL SOCIETY OF THE UNITED KINGDOM.

Thursday, March 14, 1901, G. Anderson Critchett, M. A., F. R. C. S. E., President, in the Chair.

*The Evolution of the Color Sense.*—Dr. F. W. Edridge-Green read a paper on this subject. He said the facts of color blindness threw a good deal of light on the evolution of the color sense. Cases of color blindness might be divided into two classes quite separate and distinct from each other, though both might be present in the same person. In the first class there was light as well as color loss. In the second class the perception of light was the same as the normal sighted. Many color-blind persons belonging to this class had a light perception much more acute than was found with most persons having a normal color perception. Color-blind individuals belonging to this class could be arranged in a series. At one end of this series were the normal sighted, and at the other end the totally color blind. The author had classified them in accordance with the number of colors which they saw in the spectrum, as pentachromic, tetrachromic, trichromic, dichromic and monochromic. All the facts which could be gained from the study of museums and literature pointed to the view that the sense of light was developed first, and then the sense of color, those waves which differed from each other most physically being first perceived as different—namely, red and violet. It was obvious that if a certain portion of the visual center were set apart for the perception of color, when it was very small and ill-developed it would only be able to perceive differences of considerable magnitude; but as more cells were added to the center, greater and greater power of perceiving differences arose. Each cerebral cell might at first have been connected with many optic nerve fibres, and the number gradually diminished as evolution proceeded. It need only be assumed that the nerve impulses differed in quality, for instance, in wave length, just as the waves of light differed physically in wave length, and that when a nerve impulse of a certain character acted on a cerebral cell it gave rise to a corresponding sensation of color, within the range of perceiving differences possessed by that cell. It was obvious that if the nerve impulses did not differ in quality one could never have a sensation of color. The spectrum was therefore first seen as gray, then with a tinge of red at one end and violet at the other. As the color sense developed it was not necessary that the rays should be so far apart before a differ-

ence was seen, and so the gray band gradually diminished until it entirely disappeared and the two colors met in the center of the spectrum. A third color, green, then appeared at the central point. Then yellow appeared, making four colors; then blue, making five, and finally orange, making the normal six. In some persons evolution had proceeded further, and seven colors were seen, there being two colors between the green and the violet, instead of one. It was found that paintings were first monochromatic, then red and violet were used as colors, then green, then yellow, and then blue. Homer's color vision was of the degree just preceding total color blindness. The description by different authors of the rainbow as having one, two, three, four, five, six or seven colors was very characteristic. These facts showed that color blindness was only an example of an earlier state in the development of the color-perceiving center.

*Peritomy in Episcleritis, Iritis, Herpes Ophthalmicus, and Purulent Ophthalmia.*—Mr. T. Pridgin Teale read this paper. He traced shortly the history of the operation, which was modified from syndectomy, in which a portion of the conjunctiva was excised. This, however, was found unnecessary, and if a greater effect was desired than that produced by cutting the conjunctiva round close to the cornea, it could be obtained by making several radial incisions in it. Mr. Hewetson of Leeds drew attention to the value of the operation in interstitial keratitis which the author fully endorsed. He wished to point out its great value in the other diseases mentioned, and especially in episcleritis, in which it was most marked, the pain being greatly modified. The same was noticed in obstinate cases of iritis from any cause. In a case of sub-acute purulent ophthalmia in a child with ulceration of the cornea a complete cure resulted. He had also performed the operation in a case of irido-cyclitis with increased tension where there were reasons for not performing iridectomy. In this case the operation reduced the tension to normal, and gave great relief, though it did not cure the disease.

The President said he usually removed a small ring of conjunctiva, and often with excellent results.

Mr. Cartwright thought the good effect produced was by its acting as a counter-irritant, and not in a mechanical manner.

Mr. Secker Walker had seen good results in interstitial keratitis, and also in iritis, and he looked upon its action as being similar to that of a leech.

Mr. Hern said he removed a piece of conjunctiva, and curetted round the wound. He felt it was a much-neglected operation.

Remarks were also made by Messrs. Marcus Gunn, Johnson Taylor and Cropper.

*Membranous Conjunctivitis.*—Mr. J. F. Bullar described a case. The patient was a child, who was born on October 28, 1900, and who was quite well when seen on November 5. On November 7 the right eye was noticed to be affected, and was treated by the nurse until November 11, when it became much worse, and the doctor was called in. When Mr. Bullar first saw it the lids were very much swollen, a yellowish membrane was present, which stripped off easily and left a slightly bleeding surface. Nitrate of silver of gr. ij ad oz. j was used. The eye got better, the chemosis subsided, leaving a small central ulcer of the cornea. Membrane was also noticed on the right side of the nose and fauces, which extended. The child died in convulsions on November 20. There was no diphtheria in the neighborhood, and the membrane was not examined.

Mr. Sydney Stephenson made it a rule to use antitoxin on first seeing a case, without waiting to verify the diagnosis bacteriologically.

The President said Mr. Tweedy, who had had great experience in these cases, looked upon quinine as being a specific in diphtheritic conjunctivitis, and he had himself seen great benefit arise therefrom.

Mr. Lang said that Mr. Tweedy's observations had been made long before antitoxin was known, and he thought it should not go forth as the opinion of the society that his view was still held.

Mr. Devereux Marshall said he should not think of waiting to conduct a bacteriological examination (though this would not take long), but in a case of supposed diphtheritic conjunctivitis he should at once inject antitoxin, which in no case could do harm, and in a true case the sooner it was done the better. With regard to the local application of quinine he strongly approved of it, though he had not seen its use followed by such excellent results as those obtained by Mr. Tweedy.

*Other Papers.*—Two papers by Major H. Herbert, I. M. S., were taken as read. The first was on *hypertrophy and ossification of the tarsus.* A male Hindu, aged 33, had considerable enlargement of both upper tarsi, especially towards the outer ends, without much thickening. On the left side it was fibrous, but on the right there was considerable bone formation, which was fairly dense. A piece of

necrosed bone exposed on the conjunctival surface of the lid kept up irritation, for which the patient sought relief. The other paper was a note on the surface of the normal cornea. Over thirty normal corneæ were examined in Bombay, all of which showed more or less epithelial defect when the surface was partially dried by exposure, the upper lid being elevated from the eyeball and focal illumination and the corneal loupe being used. In some cases there were only one or two pits seen, in others many closely-set pits, in others grooves added, in others one or more large depressed patches. The depressions were all sharply defined, and their floors stippled owing to the irregular surface presented by the deeper epithelial cells. They usually began to appear within half or one minute, sometimes within a few seconds, but were generally not fully shown for two or three minutes. Repeated exposures and the instillation of cocaine sometimes caused an extensive irregular superficial exfoliation of the epithelium, which partly obscured and altered the original picture. The patients examined were all native, mostly adults. Slight conjunctivitis and localized keratitis tended to exaggerate these physiological defects. In superficial punctate keratitis some of the points stained with fluorescine appeared depressed on drying and had to be distinguished from the physiological pits above described, possibly to be seen on the same cornea.

*Card Specimens.*—The following card specimens were shown: Mr. Hartridge: (1) A capsulotomy knife; (2) case of central choroiditis simulating a neoplasm, which had been watched for fourteen years.—Mr. H. Secker Walker: A diagrammatic model to assist in the teaching of refraction.—Mr. J. H. Tomlinson: A new color perimeter.—Mr. J. H. Parsons: Coloboma of the optic nerve.—Mr. G. W. Roll: Immobility of the pupils with fundus changes.—Mr. P. Flemming: Section showing dilated nerve fibers in the retina.—Mr. Doyne: A simple form of ophthalmoscope.—Mr. Work Dodd: A case of high hypermetropia.

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## SECTION ON OPHTHALMOLOGY.
## COLLEGE OF PHYSICIANS OF PHILADELPHIA.

Meeting, March 19, 1901. Dr. Wm. Thomson, Chairman, in the chair.

Dr. B. Alex. Randall exhibited a young soldier with *Recurring Hemorrhage in the Anterior Chamber.* He had been invalided home

from China for eye trouble and had come five days before to the Methodist Hospital with his left anterior chamber half-filled with fresh blood. There had been no trouble up to the attack upon Pekin, when the eyes of many were filled with dust from the shattered wall, but all direct trauma to his own eyes was denied. He had been under treatment for dysentery, for throat trouble, and for ear trouble, was still hoarse from chronic laryngitis, but presented no specific manifestations except Hutchinson teeth. The gums and nose had been prone to bleed, especially since the privations of the China expedition, but he did not seem now scorbutic, and the right eye had at no time been more than sympathetically affected. There was profuse lacrimation, with conjunctival and ciliary injections, the iris dilated sluggishly under atropin, and an anterior capsular opacity was dimly seen through the hazy cornea. But little light-reflex could be obtained from the fundus and the field seemed limited to a small temporal area of quantitative perception; tension little, if at all, raised. Under a firm compress the blood absorbed in two days to a small equatorial band; but in three days more it had again half-filled the anterior chamber. Pain had never been severe and was almost absent under atropin and the bandage. As the question of enucleation might arise should the recurrences continue, the diagnosis, especially as to the presence of an entozoon, seemed important.

Dr. G. C. Harlan exhibited a case of *Degeneration of the Pigmentary Layer of the Retina* occurring in a young colored girl, aged 14. There was a distinct circumscribed area of pigment degeneration in the macular region, through portions of which could be seen the red reflex of the choroidal vessels. The choroid did not seem to be implicated in the disease.

Dr. Wm. Thomson exhibited two patients presenting the *Results of Extraction of Steel from Vitreous.* In one case the steel was lodged near the optic disc in a mass of exudate, and was removed by forceps and scissors in May, 1897, after location of the metal by the X-rays. It was the first case to demonstrate the accuracy of Sweet's method of localization, full details of treatment being given in a paper read before the American Ophthalmological Society in that year. At the present time the eye presents a fair cosmetic appearance. The commissure is slightly smaller than its fellow, and the ball deeper in the orbit, but the cornea is clear and bright. The iris is drawn down to the outer side, and the pupil closed to a small black streak. The

eyeball is soft, but there has been no pain or tenderness. The man returned for occasional pain in his good eye, and a dull headache. There was no evidence of sympathetic trouble, the asthenopia being due to a hyperopia of + 1.25. In the second case the steel was removed by the magnet through an incision made at the corneoscleral junction of the extraction of the cataractous lens. An iridotomy and a needling of some opaque capsule were subsequently done. The eyeball at this time, six months after the accident, was free from pain and signs of inflammation. Vision equaled $\frac{1}{8}$, with + 10 Sph.=+ 5 Cyl. axis 90°.

Dr. Wm. Zentmayer reported *Three Cases of Intoxication-amblyopia with Retinal Hemorrhages* in which the abuse of alcohol predominated. The hemorrhages were found in the fiber-layer of the retina in the vicinity of the optic disc and usually overlying a vessel. The literature of the subject was reviewed, showing that in 17 cases in which the toxic agent used to excess was noted, in 14 instances it was alcohol. Dr. Zentmayer concluded that, clinically and pathologically considered, it is probable that the hemorrhages result from the giving way of vessel walls diseased by alcohol under the increased intravascular tensions caused by the pressure of the inflamed nerve-fibers.

Discussion.—Dr. de Schweinitz agreed with Dr. Zentmayer that the probable cause of the retinal hemorrhages which not infrequently were seen in cases of toxic amblyopia were due to degenerative changes in the small retinal vessels, and also believed that when they did occur, alcohol was more potent in their production than tobacco; in fact, he did not know of a pure case of tobacco amblyopia in which they had been reported, all of the types being mixed. He referred to several cases that he himself had seen, in two of which there was an association of Bright's disease.

Dr. G. E. de Schweinitz reported a case of *Rupture of the Sphincter of the Iris and V-Shaped Rupture of the Choroid on the Nasal Side* which had been produced by a blow on the eye with the end of a golf club. After referring to the statistics of choroidal rupture, he stated that the points of interest in this case were that with the choroidal rupture there was a rupture of the sphincter of the iris, and that the choroidal lesion was a wide V-shaped break in the choroid and retina situated upward and inward from the disc. Dr. de Schweinitz also reported a case of *Subconjunctival Dislocation of the Lens*

in which the dislocated lens was situated upward and inward above the corneoscleral margin and was removed ten days after the accident. The eye healed kindly, and two months later, with proper correcting lenses, there was secured a vision of one-half of normal.

Dr. Wm. M. Sweet reported *Three Cases of Rupture of the Iris from Contusion of the Eyeball,* two showing rupture at the pupillary border and in the continuity of the iris, while in one the tear was at the pupillary margin alone. He agreed with Harlan that rupture of the iris at the pupillary border is much more common than is usually supposed, being mistaken for traumatic paralytic mydriasis. In one of the cases reported several of the ruptures in the continuity of the iris were radiating in character, this being the rarest form of injury to the iris from contusion of the eyeball. In the other case of rupture in the continuity of the iris the tear was perpendicular to the radiating fibers, the wound gaping when the pupil was contracted with eserin. In only one of the cases could the accommodation be taken, and here the near point was the same for both the good and the injured eye. In the case with both pupillary and radial ruptures there was no change seen in the condition of the mydriasis one and one-half years after the injury.

Discussion.—Dr. Risley said that the point of selection in rupture of the choroid from blows on the eyeball was well illustrated by a case he had seen at the Wills Hospital, where, after enucleation, a double rupture of all of the coats of the ball was found, one on the temporal part of the globe, commencing back of the equator and extending to the macular region; the other, not so large, at a corresponding point on the nasal side of the globe. Dr. Harlan exhibited drawings of several cases of rupture of the iris that he had previously reported, in one of which there was a number of radial tears in the continuity of the iris.

Dr. Geo. C. Harlan spoke in favor of the more frequent use of the ligature recommended by Szokalsi in the *Treatment of Pterygium.* He had tried it many years ago with results more satisfactory than by any other operation, but had given it up on account of the occurrence in one case of a rather serious tenonitis. Since then his routine treatment had been lozenge-shaped excision in small pterygia and the splitting and transplanting operation advised by Knapp in larger ones; always separating the point of the pterygium from the cornea by the tearing process recommended by Prince. Recently, hoping that anti-

sepsis and ice might prevent excessive reaction, he had resorted to the ligation again, with very satisfactory results. In several cases operated upon there had been no serious inflammation, the ligated portion had separated in from four to five days, and the resulting cicatrix had been less contracted and smoother than after excision.

Discussion.—Dr. Risley was glad that Dr. Harlan had revived the old operation for pterygium by this ingenious ligature. He had formerly employed it almost exclusively with most satisfactory results until in one case he had lost the inner half of the cornea from ulceration. He believed that the failure in other forms of operation was often due to the removal of the subconjunctival tissue instead of confining the excision to the conjunctiva.

WILLIAM M. SWEET,
*Clerk of Section.*

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Treatment of Blepharitis.—Pyle, as noted in the Phila. Med. Jour., states that too much attention cannot be given to the causal conditions; careful attention to refraction, and any disturbance of the oculo-motor apparatus should be remedied. If chronic conjunctivitis co-exists, which is the rule, a mild stimulating astringent should be used. He recommends the following:

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|---|---|---|---|---|
| R. | Acidi borici | gr. xlv | 2 | 66 |
| | Sodii chloridi | gr. x | | 66 |
| | Zinci chloridi | gr. ii | | 12 |
| | Aq. destil | oz. iv | 128 | |

M. Sig.: A few drops to be instilled into each eye three times a day.

He states that all scales and crusts should be carefully removed, morning and night. Absorbent cotton moistened with warm water, warm boric-acid solution or warm bichlorid of mercury solution—1 to 5,000—may be used to loosen the accumulated secretions. Any underlying ulcers should be cleansed, the cilia epilated, and the cavities painted with a 2 per cent solution of silver nitrate. The application of a fatty substance facilitates removal of crusts, softens the skin and prevents further occlusion of the glands. For this purpose he advises the following:

| | | | |
|---|---|---|---|
| R. | Hydrargyri oxidi flavi | gr. i | 06 |
| | Vaselini | gr. iii | 18 |

M. Sig.: Rub in thoroughly a piece the size of a match-head each morning and night, after having removed the crusts, dried secretions, etc.

# NEWS ITEMS.

*Personals and items of interest should be sent to*
*Dr. Frank Allport, 92 State Street, Chicago.*

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Dr. H. P. Engle and wife, of Newton, Iowa, will spend the summer in Europe.

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At a recent meeting of the German Hospital of Buffalo, N. Y., Drs. Lucien Howe and Julius Pohlmann were appointed Oculists.

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At a meeting of the Fanny Allen Hospital of Burlington, Vermont, Dr. H. E. Lewis was appointed Oculist and Dr. C. Zaugg Consultant.

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At a recent meeting of the Tri-State Medical Society Dr. E. Sisson, of Keokuk, Iowa, read a paper on "The Eyes of Our School Children."

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Dr. Murphy, of Mason City, Iowa, has been appointed Oculist to the Chicago, Milwaukee & St. Paul Ry., and also to the Mason City and Clear Lake Ry.

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Dr. Edward E. Blaauw has been appointed editor of Dutch ophthalmic literature in the Annals of Ophthalmology, in the place of Dr. Wendell Reber, resigned.

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French Congress of Ophthalmology.—This congress is to convene at Paris, May 6. The subject announced for discussion is "The Value of Iridectomy in Glaucoma."

Dr. E. C. Ellett, of Memphis, has removed to Randolph Building

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Darier recommends Dionin (1-2 or 1 per cent solution) in iritis with posterior synechia.

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Dr. Cornelius Williams, of St. Paul, has been elected President of the St. Paul Medical Society.

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Dr. John Herbert Claibourne, Jr., was married to Miss Louisa Claibourne at New Orleans April 16th.

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St. Joseph's Hospital, at Lorain, Ohio, has appointed Drs. O. B. Mono-Smith and H. W. Patrick as Oculists.

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Dr. Melville Black, of Denver, has been appointed ophthalmologist and otologist to St. Anthony's Hospital.

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At a recent meeting of the Good Samaritan Hospital of Lexington, Ky., Dr. Charles W. Norris was appointed oculist.

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At a recent meeting of the Lansing Hospital of Lansing, Mich., Dr. Johnson W. Hagadom was appointed Oculist.

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At a meeting of the German Hospital, Kansas City, Drs. B. E. Fryer and J. H. Thompson were appointed Oculists.

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Dr. Clarence A. Veasey has been appointed Ophthalmic Surgeon to the Methodist Episcopal Hospital of Philadelphia.

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A bill to bring oculists under the jurisdiction of the State Medical Board has been introduced in the Minnesota legislature.

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Dr. Henry J. Herrick, Jr., has been appointed Assistant Ophthalmologist at the Eye Clinic, Lakeside Hospital, Cleveland.

Dr. L. Webster Fox, of Philadelphia, has been appointed a member of the Board of Managers of the Orthopedic Hospital.

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At a meeting of the Charity Hospital, New Orleans, La., Drs. P. Reiss, E. W. Jones and E. Jowers were appointed Oculists.

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Dr. Christian R. Holmes has been elected President of the Cincinnati Society of Natural History, and Dr. Arch. I. Carson Secretary.

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An ophthalmologic light is apparently beginning to break upon the English profession. While a number of American oculists are guilty of ignoring and belittling the very thing of which they should be proudest, and wearily continue to grind out the wheezy monotone of endless papers on operations and inflammatory diseases, the president of the Section on Ophthalmology of the British Medical Association devotes his presidential address to the all-important subject of refraction and ocular headache. We hope that his bravery may hereafter encourage our ophthalmologists to devote at least one paper in forty to subjects constituting nine-tenths of their daily practice, and that the operative mania may in the next one or two hundred years be relegated to its proper scientific place. Dr. Brailey should be heartily congratulated by discerning American oculists, although he is compelled to throw the inevitable sop to the conservative Cerberus by saying (what is not true) that "the great majority of headaches are, of course, independent of the eyes." We can also smile as cynically as the lecturer when he tails up with the charming astigmatic glance at "the citizens of the United States, who are eminently affected by ocular errors, so that a series of doctors and operators has arisen to take charge of that special subsection of practice." What a picture is incidentally drawn in the histories of some of his cases—for instance, in that of the poor woman with only a slight exophoria who, during twenty years, had been ordered eighteen changes of glasses by her London ophthalmologist, who each time increased her "supporting" prisms bases in. Her disease was a slight hyperphoria. Although the increase of adduction by prism-gymnastics and many other things routine in American practice have not been able to cross the Atlantic, we are too glad of the dawning to criticise the clouds that temporarily, we hope, obscure the sun.—*Philadelphia Medical Journal.*

*Lachrymal Disease*.—In cases of epiphora it is not infrequent that the condition becomes a constant menace, threatening a cause ulcer of the cornea or phlegmonous inflammation, the radical operation is apparently demanded. Lancaster discusses the indications in these cases and favors the removal of the sac as producing diminution of the cavity and the size of the lachrymal gland, though there is often still considerable surplus of secretion. If, however, the condition of the patient is critical the operation is only a partial success in many cases, and here he favors removal of the gland itself. There are some cases where removal of the gland without removal of the sac seems to promise relief, as where, for instance, there is no obstruction to the lachrymal passage, and yet the epiphora is great. Favorable results from this procedure are reported by De Wecker and others. The disadvantages or dangers of the ordinary treatment are direct and indirect. Among the first he would include the possibility of failure of preliminary healing of the wound, entailing prolonged treatment, with more or less disfiguring scars, and if infection occurs and extends to the orbit there is the possibility of orbital abscess. There is a conceivable possibility of orbital hemorrhage occurring after extirpation and the possibility of causing ptosis by damaging the levator has been suggested. So far he knows of none of these that have occurred, excepting the first. Some operators have failed to get primary union. The direct unfavorable results are the chance of having too great dryness of the cornea after extirpation of the gland. There is also the chance of injuring the cornea by lack of care. If the eye, after the operation, should become infected, it seems a lack of irrigation would be of a decided disadvantage and necessitate frequent artificial irrigation to take the place of the natural. Against this, however, there is the fact that the removal of the sac, which is the focus of infection, renders such keratitis or conjunctivitis less likely to occur. He knows of but one instance of serious complication following operation for the removal of the sac and gland. This was reported by Veasey, and it seems clear that the keratitis which occurred was an unusual type, and not to be regarded as the result of the operation per se. He reports five cases in which he has operated, in all satisfactory to the patient.—*Boston Medical & Sur. Journal.*

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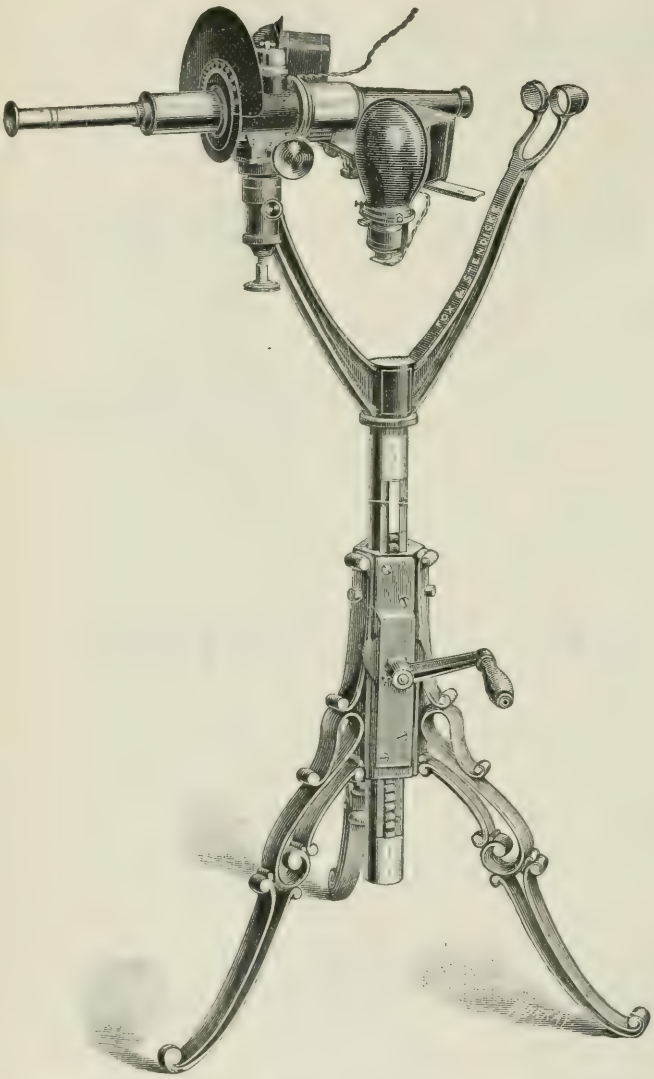

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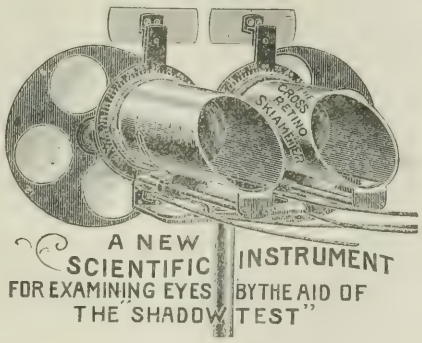


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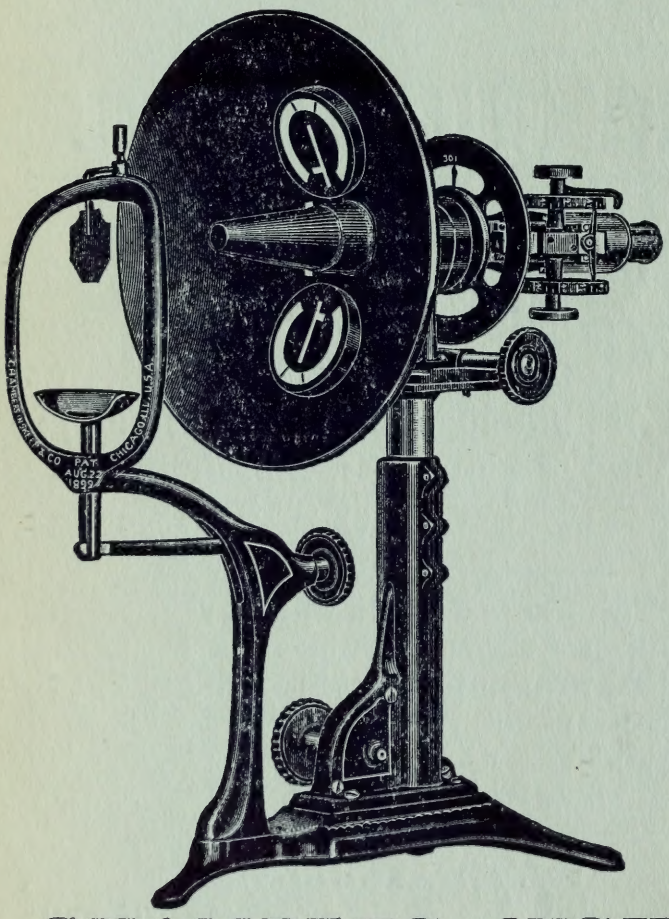


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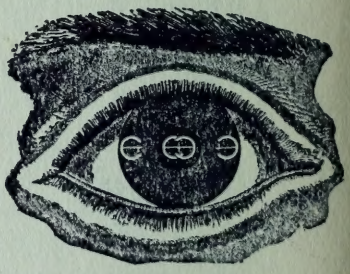

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